The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Office of General Counsel
239 Causeway Street, Suite 500, Boston, MA 02114

DEVAL L. PATRICK
GOVERNOR

JOHN W. POLANOWICZ
SECRETARY

CHERYL BARTLETT, RN
COMMISSIONER

Tel: 617-973-0800
TTY: 617-973-0988
Fax: 617-973-0986
www.mass.gov/dph/boards

August 13, 2013

By First Class and Certified Mail
No. 7012 3460 0001 7331 1074

Judith I. Willoughby
redacted

I do hereby certify the foregoing to be a true and certified copy of the document on file with the Massachusetts Board of Registration in Nursing.

Authorized Signature 9/17/13 Date

RE: In the Matter of Judith I. Willoughby, LPN License No. 20385
Board of Registration in Nursing, Docket No. NUR-2012-0019

Dear Ms. Willoughby:

I am writing to inform you that the Board of Registration in Nursing (Board) has received and accepted your letter dated August 6, 2013, in which you state that you are relinquishing your right to renew your nursing license (which expired on April 30, 2011), in resolution of the complaint against your license and the allegations set forth in Docket No. NUR-2012-0019. This complaint alleges that while employed as a Licensed Practical Nurse at Radius HealthCare Center in Worcester, Massachusetts ("Radius"), you restrained a patient ("Patient A") without authorization by tying her with a sheet to a geri-chair. The complaint further alleges that you did not document the patient's clinical condition, or contact Patient A's physician, prior to the application of the restraint.

By surrendering your right to renew your license to practice as a Licensed Practical Nurse, you can no longer practice as a nurse in Massachusetts and cannot renew said license. You are also waiving your right to a formal hearing concerning the allegations in Docket No. NUR-2012-0019, including the right to call witnesses, to confront and cross-examine adverse witnesses, and to present evidence or testify on your own behalf, as well as other rights of a formal hearing as set forth in Massachusetts General Laws Chapter 30A, and 801 CMR 1.00 *et seq*. In addition, the Board will treat your license surrender as disciplinary action with respect to the above-referenced matter for all purposes of the Board. Please sign and return this letter to my attention at the address above.

The surrender of your right to renew your nursing license in connection with this matter will continue indefinitely (Surrender Period). Should you seek relicensure at some future date, you will be required to submit a written petition for relicensure with documentation satisfactory

to the Board that demonstrates your ability to practice nursing in a safe and competent manner. Such documentation must include, but is not limited to all of the following.

(1) Information satisfactory to the Board, addressing the allegations presented by the above-referenced complaint.

(2) A written evaluation from each of your employers, if any, during the Surrender Period, addressing your general job performance, attendance and reliability.

(3) Documentation satisfactory to the Board of your successful completion of six (6) contact hours on the subject of the use of physical restraints, three (3) contact hours on the subject of the legal and ethical aspects of nursing, and three (3) contact hours on the subject of patient rights, all of which must be taken *in addition to* any contact hours required for license renewal.

(4) Documentation satisfactory to the Board of your successful completion of all continuing education required by Board regulations within the two (2) license renewal cycles immediately preceding any request for relicensure.

After its review of any petition for license reinstatement, the Board may choose to approve your petition if it determines that such action is in the best interests of the public at large. If the Board does approve your request, it may, however, condition your relicensure on your entering into a consent agreement for the PROBATION of your nursing license for a period of time (Probationary Period). The Probationary Period shall be for a duration, and include requirements, that the Board shall determine at the time of any relicensure are reasonably necessary in the best interests of the public health, safety and welfare.

Please note carefully, if you object to any of the information stated in this letter or wish to reserve your rights to full adjudication regarding the above-referenced complaint, you must contact me in writing within twenty-one (21) days of the date of this letter.

You may call me at (617) 973-0838 if you have any questions.

Sincerely,

Eugene Langner
Prosecuting Counsel

EL

To Be Completed by Board Staff No Earlier than Twenty-one (21) Days After the Date of this Letter:

~~As of this~~ day, September 3, , 2013, I have verified that Judith Willoughby HAS - HAS NOT (circle one) objected or otherwise responded to this letter.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

Tel: 617-973-0800
TTY : 617-973-0988
www.mass.gov/dph/boards

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

May 26, 2016

Mary T. Ahr
redacted

RE: In the Matter of Mary T. Ahr, Board of Registration in Nursing,
Docket No. NUR-2012-0050, License No.: RN153868

NOTICE OF RESTORATION OF UNRESTRICTED LICENSURE
(SUCCESSFUL COMPLETION OF PROBATION)

Dear Ms. Ahr:

On March 4, 2013, you entered into a Post Surrender Consent Agreement for Probation (the "Agreement") with the Board of Registration in Nursing ("Board") for no less than six (6) months. Per the terms of the Agreement, the Board placed your license to practice as a nurse on probation and required that you fulfill specific requirements.

Please be advised that after review and as authorized by Board policy 15-01, Board staff have determined that you have complied in full with all requirements of the Agreement and that the probationary period has been satisfied. Accordingly, I am restoring your license to full, unrestricted status, effective May 24, 2016. Please allow for up to five (5) business days from the date of this letter until the updated license status appears on the "Check a License" website.

Congratulations on your successful completion of Stayed Probation. If you have any further questions, you can contact me directly at 617-973-0951.

Sincerely,

Karen L. Fishman

Karen L. Fishman
Probation Monitor

KLF/cp

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of
Mary T. Ahr
RN License No. 153868

Docket No. NUR-2012-0050

POST SURRENDER CONSENT AGREEMENT FOR PROBATION

The Massachusetts Board of Registration in Nursing (Board) and Mary T. Ahr (Licensee), a Registered Nurse (RN) licensed by the Board, License No. 153868, do hereby stipulate and agree that the following information shall be entered into and become a permanent part of the Licensee's record maintained by the Board:

1. The Licensee agrees that this Post-Surrender Consent Agreement for Probation ("Agreement") will supercede any and all previous agreements that she has entered into with the Board. Further, the Licensee agrees that this Agreement has been executed as a result of the Board's:

   a. receipt and investigation of a complaint filed against her, Docket NUR-2012-0050, which resulted in the surrender of her nursing licence, pursuant to a Surrender Agreement with the Board effective July 19, 2012 in resolution of the complaint; and

   b. consideration of the Licensee's request for license reinstatement and documentation she submitted pursuant to the requirements of the Post-Surrender Consent Agreement referenced in the subparagraph immediately above.

2. The Licensee admitted that while employed as a Registered Nurse at New Bedford Rehabilitation Hospital in New Bedford, MA, on or about January 24, 2012, she administered Patient A's medication to Patient B in addition to administering Patient B's medication. The Licensee failed to report her error at the time and did not properly monitor Patient B after she realized her eror. The Licensee did contact the facility after she left to report the error. The Licensee acknowledged that her conduct constitutes failure to comply with the Board's Standards of Conduct at 244 Code of Massachusetts Regulations (CMR) 9.03(5), (15), (31), (38), (39), (44) and (47) and warranted disciplinary action by the Board under

Massachusetts General Laws (G.L.) Chapter 112, section 61 and Board regulations at 244 CMR 7.04, Disciplinary Actions.

3. The Licensee agrees that her nursing license shall be placed on **PROBATION** for no less than **six (6) months** (Probationary Period), commencing with the date on which the Board signs this Agreement (Effective Date).

4. During the Probationary Period, the Licensee further agrees that she shall comply with all of the following requirements to the Board's satisfaction:

   a. Comply with all laws and regulations governing the practice of nursing, and not engage in any continued or further conduct such as that set forth in Paragraph 2.

   b. Notify the Board in writing within ten (10) days of each change in her name and/or address.

   c. Timely renew her license to practice nursing.

   d. Maintain active employment in a position that requires a nursing license, in a setting where the Licensee receives consistent, on-site supervision by a qualified licensed nurse[1], for a minimum average of twenty (20) hours per week throughout the Probationary Period. The Licensee may not accept any home care, travel or temporary staffing assignment, or practice where consistent, on-site supervision is not in place.

      i. If the Licensee is not employed in accordance with Paragraph 4d at any time during the Probationary Period, she shall notify the Board's Probation Monitor in writing within thirty (30) days.

   e. Review this Agreement with each of her nursing supervisors, and arrange for each nursing supervisor to submit directly to the Board:

      i. a completed and signed "Supervisor Verification Form" (Form 1), provided with this Agreement, within thirty (30) days of

         (1) the Effective Date *and*

         (2) any subsequent employment commenced during the Probationary Period

[1] The Licensee must receive direct supervision from a licensed nurse who must have at least one (1) year of clinical nursing practice experience, no open complaints, no past discipline of the nurse's license, and who is physically located at all times in each facility in which the Licensee practices nursing.

ii. *quarterly* written reports[2], using the "Supervision Report Form" (Form 2) provided with this Agreement attesting to the quality of the Licensee's nursing practice, reliability and attendance and specifically addressing Licensee's medication administration including any errors and incidents[3].

f. Notify the Board in writing within ten (10) days of any change in the Licensee's employment status, including each change in Employer, each resignation or termination, and the name, address and telephone number of each new Employer.

5. The Board agrees that in return for the Licensee's execution and successful compliance with all the requirements of this Agreement it will not prosecute the Complaint.

6. If the Licensee has complied to the Board's satisfaction with all the requirements contained in this Agreement, the Probationary Period will terminate **six (6) months** after the Effective Date upon written notice to the Licensee from the Board[4].

7. If the Licensee does not comply with each requirement of this Agreement, or if the Board opens a Subsequent Complaint[5] during the Probationary Period, the Licensee agrees to the following:

a. The Board may upon written notice to the Licensee, as warranted to protect the public health, safety, or welfare:

i. EXTEND the Probationary Period; and/or

ii. MODIFY the Probation Agreement requirements; and/or

iii. IMMEDIATELY SUSPEND the Licensee's nursing license.

b. If the Board suspends the Licensee's nursing license pursuant to Paragraph 7(a)(iii), the suspension shall remain in effect until:

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[2] The Licensee is responsible for ensuring that these reports on the required form are received by the Board commencing ninety (90) days after the Effective Date and on the first day of every third month thereafter.
[3] The Board may take action under paragraph 7 in the event that the reports reveal a practice issue which the Board deems significant.
[4] In all instances where this Agreement specifies written notice to the Licensee from the Board, such notice shall be sent to the Licensee's address of record.
[5] The term "Subsequent Complaint" applies to a complaint opened after the Effective Date, which (1) alleges that the Licensee engaged in conduct that violates Board statutes or regulations, and (2) is substantiated by evidence, as determined following the complaint investigation during which the Licensee shall have an opportunity to respond.

i. the Board gives the Licensee written notice that the Probationary Period is to be resumed and under what terms; or

ii. the Board and the Licensee sign a subsequent agreement; or

iii. the Board issues a written final decision and order following adjudication of the allegations (1) of noncompliance with this Agreement, and/ or (2) contained in the Subsequent Complaint.

8. The Licensee agrees that if the Board suspends her nursing license in accordance with Paragraph 7, she will immediately return her current Massachusetts license to practice as a Registered Nurse to the Board, by hand or certified mail. The Licensee further agrees that upon said suspension, she will no longer be authorized to engage in the practice of nursing in the Commonwealth of Massachusetts and shall not in any way represent herself as a Registered Nurse until such time as the Board reinstates her nursing license or right to renew such license[6].

9. The Licensee agrees that when she executed the original Consent Agreement for Surrender that she entered into with the Board in final resolution of the above-captioned complaint, Docket No. NUR-2012-0050 effective on July 19, 2012, she knowingly and voluntarily waived her right to a formal adjudication concerning the allegations against her in the complaints, the rights that she would have possessed during such adjudication to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on her own behalf, to contest the allegations, to present oral argument, to appeal to the courts, and to all other rights as set forth in the Massachusetts Administrative Procedures Act, G. L. c. 30A, and the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 *et seq.* The Licensee further understands and agrees that in executing this document entitled "Post-Surrender Consent Agreement for Probation," she is knowingly and voluntarily waiving any rights she has to a formal adjudication concerning the Board's action on her request for termination of her surrender of her nursing license in connection with the above-captioned complaint, the rights that she would possess during such an adjudication and to those other rights listed above.

10. The Licensee acknowledges that she has been at all times free to seek and use legal counsel in connection with the complaint and this Agreement.

11. The Licensee acknowledges that after the Effective Date, the Agreement constitutes a public record of disciplinary action by the Board. The Board may

[6] Any evidence of unlicensed practice or misrepresentation as a Registered Nurse after the Board has notified the Licensee of her license suspension shall be grounds for further disciplinary action by the Board and the Board's referral of the matter to the appropriate law enforcement authorities for prosecution, as set forth in G.L. c. 112, §§ 65 and 80.

forward a copy of this Agreement to other licensing boards, law enforcement entities, and other individuals or entities as required or permitted by law.

12. The Licensee certifies that she has read this Agreement. The Licensee understands and agrees that entering into this Agreement is a voluntary and final act and not subject to reconsideration, appeal or judicial review.

2/25/13 — Witness (sign and date)

Mary T. Ahr 2/25/13 — Mary T. Ahr, Licensee (sign and date)

EDWARD J AHR JR. — Witness (print name)

Rula Harb, MSN, RN
Executive Director
Board of Registration in Nursing

March 4, 2013
Effective Date of Agreement

Fully Signed Agreement Sent to Licensee on March 4, 2013 **by Certified Mail No.** 7009 2250 0001 8154 7902

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of
Mary T. Ahr
RN License No. 153868
Expires 5/2/14

Docket No. NUR-2012-0050

CONSENT AGREEMENT FOR VOLUNTARY SURRENDER

The Massachusetts Board of Registration in Nursing (Board) and Mary T. Ahr (Licensee), a Registered Nurse (RN) licensed by the Board, License No.153868, do hereby stipulate and agree that the following information shall be entered into and become a permanent part of the Licensee's record maintained by the Board:

1. The Licensee acknowledges that a complaint has been filed with the Board against her Massachusetts Registered Nurse license (license[1]) related to the conduct set forth in paragraph 2, identified as Docket No. NUR-2012-0050 (the Complaint).

2. The Licensee admits that while employed as a Registered Nurse at New Bedford Rehabilitation Hospital in New Bedford, MA, on or about January 24, 2012, she administered Patient A's medication to Patient B in addition to administering Patient B's medication. The Licensee failed to report her error at the time and did not properly monitor Patient B after she realized her error. Licensee did contact the facility after she left to repor the error. The Licensee acknowledges that her conduct constitutes failure to comply with the Board's Standards of Conduct at 244 Code of Massachusetts Regulations (CMR) 9.03(5), (15), (31), (38), (39), (44) and (47) and warrants disciplinary action by the Board under Massachusetts General Laws (G.L.) Chapter 112, section 61 and Board regulations at 244 CMR 7.04, Disciplinary Actions.

3. The Licensee agrees to **SURRENDER** her nursing license for no less than **six (6) months (Surrender Period)**, commencing with the date on which the Board signs this Agreement (Effective Date).

[1] The term "license" applies to both a current license and the right to renew an expired license.

4. After the Surrender Period, and when the Licensee can complete to the satisfaction of the Board all of the requirements set forth in this Paragraph the Licensee may petition the Board for reinstatement of her license. The petition must be in writing and must include the following documentation of the Licensee's ability to practice nursing in a safe and competent manner, all to the Board's satisfaction:

   a. Evidence of completion of all continuing education required by Board regulations for the two (2) renewal cycles immediately preceding the date on which the Licensee submits her petition ("petition date");

   b. A performance evaluation sent directly to the Board from each of the Licensee's employers, prepared on official letterhead that reviews the Licensee's attendance, general reliability, and specific job performance during the year immediately prior to the petition date[2].

   c. Written verification sent directly to the Board from each of the Licensee's medical care providers, which meets the requirements set forth in Attachment B 1;

   d. Authorization for the Board to obtain a Criminal Offender Record Information (CORI) report of the Licensee conducted by the Massachusetts Criminal History Systems Board.

   e. Documentation that the Licensee has completed, at least one (1) year prior to the petition date, all requirements imposed upon her in connection with all criminal and/or administrative matter(s) arising from, or related to, the conduct identified in Paragraph 2[3]. Such documentation shall be certified and sent directly to the Board by the appropriate court or administrative body and shall include a description of the requirements and the disposition of each matter.

   f. Certified documentation from the state board of nursing of each jurisdiction in which the Licensee has ever been licensed to practice as a nurse, sent directly to the Massachusetts Board identifying her license status and discipline history, and verifying that her nursing license is, or is eligible to be, in good standing and free of any restrictions or conditions.

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[2] If the Licensee has not been employed during the year immediately prior to the petition date, she shall submit an affidavit to the Board so attesting.

[3] If there have been no criminal or administrative matters against the Licensee arising from or in any way related to the conduct identified in Paragraph 2, the Licensee shall submit an affidavit so attesting.

g. Submit documentation that she has successfully completed the following continuing education[4] after the Effective Date,

i. Six (6) contact hours on Medication Administration and Documentation in Nursing which includes the topic of Medication Error Reduction;

ii. Three (3) contact hours on Legal and Ethical Aspects of Nursing;

iii. Three (3) contact hours on Critical Thinking and Judgment in Nursing Practice and;

iv. Six (6) contact hours on Head to Toe Patient Assessment Skills.

5. The Board may choose to reinstate the Licensee's license if the Board determines that reinstatement is in the best interests of the public at large. Any reinstatement of the Licensee's license shall be conditioned upon the Licensee entering into a consent agreement for the PROBATION of her license for at least six (6) months, and including requirements, that the Board determines at the time of relicensure to be reasonably necessary in the best interests of the public health, safety and welfare.

6. The Licensee agrees that she will not practice as a Registered Nurse in Massachusetts from the Effective Date unless and until the Board reinstates her license[5].

7. The Board agrees that in return for the Licensee's execution of this Agreement it will not prosecute the complaint.

8. The Licensee understands that she has a right to formal adjudicatory hearing concerning the allegations against her and that during said adjudication she would possess the right to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on her own behalf, to contest the allegations, to present oral argument, to appeal to the courts, and all other rights as set forth in the Massachusetts Administrative Procedures Act, G. L. c. 30A, and the Standard

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[4] These continuing education courses must be *in addition to* any contact hours required for license renewal. They may be taken as home study or as correspondence course, *provided that* they meet the requirements of Board Regulations at 244 CMR 5.00, Continuing Education.

[5] The Licensee understands that practice as a Registered Nurse includes, but is not limited to, seeking and/or accepting a paid or voluntary position as a Registered Nurse, or a paid or voluntary position requiring that the applicant hold a current Registered Nurse license. The Licensee further understands that if she accepts a voluntary or paid position as a Registered Nurse, or engages in any practice of nursing after the Effective Date and before the Board formally reinstates her license, evidence of such practice shall be grounds for the Board's referral of any such unlicensed practice to the appropriate law enforcement authorities for prosecution, as set forth in G. L. c. 112, ss. 65 and 80.

Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 *et seq.* The Licensee further understands that by executing this Agreement she is knowingly and voluntarily waiving her right to a formal adjudication of the complaints.

9. The Licensee acknowledges that she has been at all times free to seek and use legal counsel in connection with the complaint and this Agreement.

10. The Licensee acknowledges that after the Effective Date, the Agreement constitutes a public record of disciplinary action by the Board. The Board may forward a copy of this Agreement to other licensing boards, law enforcement entities, and other individuals or entities as required or permitted by law.

11. The Licensee certifies that she has read this Agreement. The Licensee understands and agrees that entering into this Agreement is a final act and not subject to reconsideration, appeal or judicial review.

7/10/12
Witness (sign and date)

Mary T. Ahr 7/10/12
Mary T. Ahr
Licensee (sign and date)

Edward J. Ahr II
Witness (print name)

Rula Harb
Rula Harb, MSN, RN
Executive Director
Board of Registration in Nursing

July 19, 2012
Effective Date of Surrender Agreement

Fully Signed Agreement Sent to Licensee on July 19, 2012 **by Certified Mail No.** 7012 0470 0001 3526 6189

Ahr, Mary
NUR-2012-0050
RN153868

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

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TTY : 617-973-0988
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MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

June 12, 2018

By first-class and certified mail no. 7017 0530 0000 0551 5467,
return receipt requested
Jeremy T. Robin, Esq.
P.O. Box 146727
Boston, MA 02114

RE: **In the matter of Dr. David Satloff, License No. DN15101**
Board of Registration in Dentistry, Docket Nos. DEN-2012-0122 & DEN-2013-0178

Dear Attorney Robin:

Enclosed is the Ruling on Respondent's Objections ("Ruling") issued by the Board of Registration in Dentistry ("Board") in connection with the matter refereneed above. The effective date of the Board's Ruling is the Date Issued.

The Board also reviewed Respondent's Motion to Enlarge Time to File Objections and for Permission to Discuss Settlement, filed March 7, 2018 and Supplemental Motion to Enlarge Time, filed April 18, 2018 along with the Prosecutor's Responses and voted on May 2, 2018, to deny both Motions as moot and that Respondent may submit a settlement offer to the Prosecutor.

Sincerely,

Barbara A. Young RDH

Barbara A. Young, RDH
Executive Director
Board of Registration in Dentistry

Enc.

Cc: Prosecution (by interoffice mail)
Administrative Hearing Counsel (by interoffice mail)

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN DENTISTRY

In the Matter of	)	
Dr. David Satloff	)	Docket Nos. DEN-2012-0122
License No. DN15101	)	DEN-2013-0178
Expired March 31, 2018	)	
	)	

Ruling on Respondent's Objections to Tentative Decision

Procedural Background

This matter comes before the Board of Registration in Dentistry ("Board") after the Administrative Magistrate ("AM") issued a Tentative Decision on February 15, 2018. As procedural background, the Board issued an Order to Show Cause on April 17, 2015, requiring Respondent to demonstrate why the Board should not suspend, revoke or take other action against his dental license or right to renew such license based on allegations that (1) the Respondent's diagnosis and recommended treatment of Patient A using energy testing fell below the accepted standards of care for general dentists, (2) the Respondent failed to provide dental services in compliance with *CDC Guidelines for Infection Control in Dental Health-Care Settings* (2003) under 234 CMR 5.05(1) in his North Attleboro and Seekonk offices and (3) the Respondent failed to maintain required equipment and drugs for the safe administration of local anesthesia under 234 CMR 6.15 in his North Attleboro and Seekonk dental offices.

On April 15, 2016, the Board amended its Order to Show Cause and Respondent answered, requesting an adjudicatory hearing. The AM received evidence and testimony over eleven days of hearings held over February, March and April 2017 and final arguments were held on August 16, 2017. On February 15, 2018, the AM issued the Tentative Decision pursuant to 801 CMR 1.01(11)(c). Both parties filed objections pursuant to 801 CMR 1.1(11)(e)(1) and prosecuting counsel filed responses to Respondent's Objections.

It is well settled that the Board's decision must be made on substantial evidence based upon evidence found in the record. *Fender v. Contributory Ret. Appeal Bd.*, 72 Mass. App. Ct. 755, 760 (2008). The Board's factual determinations must be supported by substantial evidence, meaning such evidence as a reasonable mind might accept as adequate to support a conclusion. *Katz v. MCAD*, 365 Mass. 357, 365 (1974). As long as the record contains substantial evidence to support the AM's findings, those findings will not be disturbed. *Arthurs v. Board of Registration in Medicine*, 383 Mass. 299, 305 (1981). In addition, the Board "may not reject a[n] [administrative magistrate's] tentative

determinations of credibility of witnesses personally appearing" 801 CMR 1.01(11)(c)(2). See also, *Andrews v. Civil Serv. Comm'n.*, 446 Mass. 611, 615-616 (2006).

The Tentative Decision

The Board has reviewed and carefully considered the Tentative Decision, the Respondent's objections, Prosecutor's single objection and Prosecution's responses to Respondent's objections. The Board has determined that the Respondent's objections are without merit and that no changes to the Tentative Decision are warranted, except as provided below. *Arthurs*, 383 Mass. at 315-316 and *Weinberg v. Board of Registration in Medicine*, 443 Mass. 679, 687 (2005).

The Board concurs with the Prosecution's single objection that a scrivener's error is found at ¶ 12 and finds that the preface of ¶ 12 should read "Respondent's position that the paining tooth was #30 is summarized as follows." Such change is consistent with the subsequent seven subparagraphs that outline Respondent's testimony as to his belief that it was Patient A's tooth #30 he had tested and diagnosed. See ¶ 12 (a)-(g).

The Board generally finds Respondent's seven groups of objections encompassing sixty-nine Findings of Fact (FOF) and Rulings of Law (ROL) are without merit and raise no basis for the Board to correct, modify or remand for further fact finding. The Board is not required to address each of the objections or provide a specific response for rejecting objections. *Arthurs* at 316 and *Weinberg* at 687. While declining to address each of Respondent's objections individually, the Board responds as follows:

Finding of Fact ¶ 6(c) .

Respondent objects to FOF ¶ 6(c) on the basis that such finding is "not based on the weight of the testimony or documentation, the latter including the Respondent's handwritten note entry that specified 'initial exam.'" This objection has no merit. Respondent was the only person to testify that he performed percussion, palpation and cold air syringe tests on Patient A. The AM addressed Respondent's notation of "initial exam" in Patient A's dental record, finding such a note did not necessarily indicate percussion or cold air testing was performed. Respondent's expert opined that such notation could be construed to include percussion and cold air testing if that was typically a routine part of Respondent's initial patient exams. However, Respondent's dental assistant did not testify that Respondent's initial exam included palpation, percussion or a cold air syringe tests. See ¶ 6(c)(2).

The weight of the evidence demonstrates that Respondent failed to conduct such standard diagnostic testing, which he believes is of "limited diagnostic value" and failed to record any results "because the results of those tests are frankly meaningless." The Respondent did not report on three separate responses to the Board during the investigation phase that he conducted such testing, but explicitly relied on energy testing for his diagnosis, stating "I stand by my diagnosis of an infected pulp based on the

proteomic test and discovery of the presence of l-homocysteine in tooth 19." See ¶ 6(g). The AM's factual finding is supported by substantial evidence and the Board finds Respondent's objection to ¶ 6(c) without merit.

Finding of Fact ¶ 10

Respondent objects that FOF ¶ 10 is not supported by substantial evidence. This objection has no merit. The AM found Respondent told Patient A she had the beginnings of cancer and that if she did not have a root canal or extraction she would develop cancer. The AM found Patient A's testimony credible, direct and unequivocal, as well as consistent with the complaint she filed three months after her initial exam with Respondent, in which she stated "he said that I have the beginnings of cancer." On the other hand, the AM found that the Respondent did not have a specific memory of his discussion with Patient A. See ¶ 10(ii). Here, neither Respondent nor the Board may second guess the AM's credibility determinations made with respect to Patient A. 801 CMR 1.01(11)(c)(2), see also *Doherty v. Retirement Board of Medford*, 425 Mass. 130, 141-42 (1997).

Moreover, the AM found Respondent's testimony and letters overall consistent with having told Patient A she had cancer. He testified that Patient A tested positive for a biomarker that was "related to the development possibly of pathology like cancer" and guessed he talked about "pathology" with her, although he claimed during his testimony that he did not have a specific memory of the conversation. In a letter to the Board dated July 12, 2012, he maintains that "[i]n fact, I felt it was my duty as a dental professional to inform Patient A that I had found proteomic biomarkers indicative of precancer associated with her sensitive and paining tooth." See ¶ 10(iv). The AM's factual findings in ¶ 10 are supported by substantial evidence and Respondent's objection thereto is without merit.

Findings of Fact ¶¶ 11–18

The Respondent objects to FOF ¶¶ 11–18 on the grounds that the AM's finding that it was tooth #19 and not #30 that was paining Patient A is not supported by substantial evidence. Again, Respondent's objection is baseless and without any support apart from his own testimony.

The AM lists the evidence over three pages in the Tentative Decision related to whether or not it was tooth #19 or tooth #30 that was paining Patient A and that Respondent examined. The AM summarizes Respondent's position and testimony in FOF ¶ 12, that four years after examining Patient A, he formed the believe he had tested, diagnosed and developed a treatment plan based on an image of Patient A's tooth #30. However, it is clear that substantial evidence amply supports the AM's finding to the contrary. Indeed, in summary, Patient A testified that the pain came from the second molar from the back on her left side (#19); that the radiographic image in Patient A's record was of teeth ##18-20; all Patient A's records from her visit to Respondent's office refer to #19; there is no digital or any image of tooth #30 in Patient A's record;

Respondent handwrote #19 at least three times in Patient A's record; Respondent's letters all refer to tooth #19; treatment notes from separate exams by Drs. Lavall and Balamas refer to tooth #19. The AM found Respondent's strongly held belief that a mistake was carried forward for over four years to be "implausible" and that it "rings hollow" is in part a credibility determination that cannot be reviewed or altered by the Board. Even so, Respondent's testimony does little to outweigh the substantial evidence the AM relied on in finding that it was tooth #19 (and not #30) that was paining Patient A and that Respondent diagnosed and recommended treatment for.

Findings of Fact and Rulings of Law ¶¶ 23–37

Respondent objects that FOF and ROL ¶¶ 23–37 are not supported by substantial evidence and/or are arbitrary and capricious. Here, the parties already agreed both experts did not possess expertise in the field of energy testing, but could testify as to the standard of care a general dentist would exercise in diagnosing and treating a paining tooth and whether energy testing fell within the accepted standards of care for such diagnosis and treatment. The AM's finding that the use of energy testing[1] to diagnose and treat Patient A's tooth #19 violated recognized standards of care for general dentists is amply supported in ¶¶ 24–37. In summary, the AM found that (a) energy testing is not an evidence or scientifically-based diagnostic modality in general dentistry; (b) energy testing has not been subjected to clinical trials, studies or peer-review; (c) energy testing of an image doesn't exist in today's standard of care; (d) Respondent's own submissions fail to suggest that energy testing is within the standard of care for general dentists to diagnose and treat tooth pain; (e) Respondent could not substantiate his claim that energy testing has "both state approval and state accreditation" in New York and other states and "in Massachusetts the use of AK has approval and accreditation by the division of licensure."

The AM adopted in full Dr. Farsai's testimony that energy testing to diagnose and treat Patient A's tooth pain does not fall within the accepted standards of care for general dentists, "because his testimony on such was credible, supported, and consistent with the facts." See ¶ 32. As previously stated, the AM's credibility determinations are not subject to the Board's review. *Palmer v. Board of Registration in Medicine*, 415 Mass. 121, 124 (1993). On the other hand, the AM rejected Respondent's expert's opinion, as Dr. Just's testimony was inconsistent with the facts adduced at the hearing. See ¶¶ 32–35. The AM found that "[w]hile Dr. Just may not be faulted for his erroneous understanding [of the testing conducted], the central pillar of his opinion is faulty and that alone substantially impairs is standards of care opinion regarding Respondent's diagnosis and treatment of Patient A." See ¶ 34.

[1] As used in this Ruling, "energy testing" is coterminous with the meaning the AM uses throughout her Tentative Decision and includes Bi-Digital O-Ring Testing (BDORT), Applied Kinesiology (AK) and Autonomic Resonance Testing (ART). See ¶¶ 7 and 37, fn 8.

Rulings of Law ¶¶ 38–49

Respondent articulates no cognizable basis for his objection to the AM's findings that the Respondent violated: (i) Board regulations related to maintaining a patient record at 234 CMR 5.14; (ii) standards of care in diagnosing and treating Patient A's tooth pain using energy testing; (iii) and informing Patient A that she had the beginnings of cancer based on his use of energy testing. The AM found that these violations are all valid legal grounds for the Board to discipline Respondent's dental license. The AM's rulings of law are amply supported by substantial evidence. The Board is not required to rebut each legal issue or theory presented by the Respondent, much less general, undeveloped and unsubstantiated contentions the Respondent suggests. *Weinberg* at 687.

Findings of Fact and Rulings of Law ¶¶ 60–88

Respondent objects to the AM's determination that certain mailings sent by Respondent were advertisements as not supported by substantial evidence and/or arbitrary and capricious. Respondent argues such mailings are more akin to educational statements intended to broadcast his philosophy on alternative forms of treatment and not for the purpose of obtaining business. Respondent's objection is without merit. The AM made findings in ¶ 62 and expressly rejected Respondent's contention that the mailing was for educational purposes. The AM's finding is based on substantial evidence and the Board will not disturb this finding.

Findings of Fact and Rulings of Law ¶¶ 93–94, 114

Respondent objects to the AM's finding that Respondent's North Attleboro dental office failed to conduct weekly spore testing for seven weeks in 2013 as not supported by substantial evidence. The objection is without merit. Respondent re-argues an implausible theory expressly rejected by the AM; namely, that the United States Postal Service lost seven envelopes purportedly mailed on seven occasions between January and September 2013 because one envelop for a spore testing sample mailed after the site inspection was completed was returned in a mutilated condition. The AM rejected this theory, stating that there was no showing of repeated mail processing issues that interfered with the submission of spore testing materials to Biological Monitoring Systems. See ¶ 92(c). The AM's Findings of Fact and Rulings of Law are supported by substantial evidence.

Conclusion

The Board reviewed and carefully considered the Respondent's seven groups of objections encompassing sixty-nine findings of fact and rulings of law and Prosecution's one objection. The Board finds that the Respondent's objections to the Tentative Decision are without merit. As stated, the AM thoroughly reviewed all the documentary evidence and testimony and demonstrates there is substantial evidence to support each of the AM's findings of fact and rulings of law. The Board rejects Respondent's invitation to correct, modify or remand for further fact finding.

The Board does concur with Prosecution's one objection that a scrivener's error is found at ¶ 12 and finds that the preface of ¶ 12 should read "Respondent's position that the paining tooth was #30 is summarized as follows." Such change is consistent with the subsequent seven subparagraphs that outline Respondent's testimony as to his belief that it was Patient A's tooth #30 he had tested and diagnosed. See ¶ 12 (a)-(g).

The Board voted to adopt this Ruling on Respondent's Objections to Tentative Decision at its meeting held on May 2, 2018, by the following vote:

In Favor:	Dr. Stephen C. DuLong, Dr. John Hsu, Ms. Stacy Haluch, RDH, Dr. Paul F. Levy, Dr. David Samuels, Dr. Cynthia M. Stevens, Ms. Jacyn Stultz, RDH, and Dr. Patricia Wu.
Opposed:	None
Abstained:	None
Recused:	Ms. Ailish Wilkie
Absent:	Ms. Kathleen Held, M.Ed.

Board of Registration in Dentistry

June 12, 2018
Date Issued

Barbara A. Young RDH
Barbara A. Young, RDH
Executive Director
Board of Registration in Dentistry

Notify:

By first-class and certified mail no. 7017 0530 0000 0551 5467, return receipt requested
Jeremy T. Robin, Esq.
P.O. Box 146727
Boston, MA 02114

By Interoffice mail
Beth Oldmixon, Esq.
Prosecutor
Department of Public Health
Bureau of Health Professions Licensure
239 Causeway Street
Boston, MA 02114

By Interoffice mail
Karen Gray Carruthers, Esq.
Administrative Magistrate
Department of Public Health
Bureau of Health Professions Licensure
250 Washington Street, 8th Floor
Boston, MA 02108

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

Tel: 617-973-0800
TTY : 617-973-0988
www.mass.gov/dph/boards

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

June 12, 2018

By first-class and certified mail no. 7017 0530 0000 0551 5467,
return receipt requested
Jeremy T. Robin, Esq.
P.O. Box 146727
Boston, MA 02114

RE: **In the matter of Dr. David Satloff, License No. DN15101**
Board of Registration in Dentistry, Docket Nos. DEN-2012-0122 & DEN-2013-0178

Dear Attorney Robin:

Enclosed also please find the Final Decision and Order ("Final Order") issued by the Board of Registration in Dentistry ("Board") in connection with the matter referenced above. The effective date of the Board's Final Order is ten (10) days from the date appearing on page 10 of the Final Order ("Date Issued"). Your client's appeal rights are noted on page 9 of the Final Order.

Sincerely,

Barbara A. Young RDH

Barbara A. Young, RDH
Executive Director
Board of Registration in Dentistry

Enc.

Cc: Prosecution (by interoffice mail)
Administrative Hearing Counsel (by interoffice mail)

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN DENTISTRY

In the Matter of Dr. David Satloff License No. DN15101 Expired March 31, 2018	Docket Nos. DEN-2012-0122 DEN-2013-0178

FINAL DECISION AND ORDER

Procedural History

On April 17, 2015, the Board of Registration in Dentistry ("Board") issued the Respondent an Order to Show Cause ("OTSC") requiring him to demonstrate why the Board should not suspend, revoke or otherwise take disciplinary action against his dental license or right to renew such license based on allegations that (1) the Respondent's diagnosis and recommended treatment of Patient A using energy testing fell below the accepted standards of care for general dentists, (2) the Respondent failed to provide dental services in compliance with CDC Guidelines for Infection Control in Dental Health-Care Settings (2003) under 234 CMR 5.05(1) in his North Attleboro and Seekonk offices, and (3) the Respondent failed to maintain required equipment and drugs for the safe administration of local anesthesia under 234 CMR 6.15 in his North Attleboro and Seekonk dental offices.

On April 15, 2016, the Board amended its Order to Show Cause and Respondent answered and requested an adjudicatory hearing. The complaints were assigned to Administrative Magistrate, Karen Gray Carruthers ("AM" or "AM Carruthers"), who

over eleven days of hearings held between February and April 2017 received evidence related to the OTSC's allegations. Final arguments were held on August 16, 2017 and the record was closed. On February 15, 2018, AM Carruthers issued her Tentative Decision pursuant to 801 CMR 1.01(11)(e). Both parties filed objections pursuant to 801 CMR 1.1(11)(e)(1) and prosecuting counsel filed responses to Respondent's Objections.

On May 5, 2018, the Board reviewed and carefully considered the Tentative Decision, the Respondent's objections, Prosecutor's single objection and the Prosecutor's responses to Respondent's objections and declined to make any changes to the Tentative Decision apart from a correction in paragraph 12, to now read that "the paining tooth was #30 is summarized as follows."

On June 6, 2018, the Board reviewed the Tentative Decision and after considering its Ruling on Respondent's Objection, voted to adopt the Tentative Decision in its entirety, makes the correction to paragraph 12 noted above and incorporates the Tentative Decision, as corrected, into its Final Decision.

Rationale for Sanction

After reviewing the Tentative Decision, the Board finds discipline of Respondent's license is warranted for violations of numerous Board regulations, however in fashioning a sanction, two main areas of focus stand out:

A. Non-Compliance with Infection Control and Emergency Management Requirements at Respondent's Dental Practices

At his North Attleboro practice, Respondent was found to have failed to perform weekly spore testing over multiple weeks, and failed to comply with CDC Guidelines concerning sterilization and sterile storage of equipment, and failure to maintain a written Infection Control Program with annual employee training. Respondent also failed to

maintain a current emergency drug kit, as well as drugs, equipment and supplies required for administration of local anesthesia, and failed to maintain a written protocol for managing medical and dental emergencies.

At his Seekonk practice, Respondent was found to have failed to perform weekly spore testing over multiple weeks, and failed to comply with CDC Guidelines concerning sterilization and sterile storage of equipment, and failure to maintain a written Infection Control Program with annual employee training. Respondent also failed to maintain a current emergency drug kit, as well as drugs, equipment and supplies required for administration of local anesthesia, and failed to maintain a written protocol for managing medical and dental emergencies.

Patients who seek treatment at a dental office should receive such treatment without being placed at undue risk for incurring an infection from exposure to non-sterile equipment. For this reason, the Board's regulations require dentists to not only sterilize their equipment and dental instruments, but to take steps to confirm that sterility has been achieved and maintained, which includes adhering to a regular protocol and training staff to do the same. Dentists should also be prepared to provide life-saving emergency treatment to patients who experience a reaction to treatment or other medical emergency while receiving dental care. For this reason, the Board's regulations require dentists to maintain a current stock of appropriate medications, necessary equipment, emergency protocols, and trained staff for responding to medical and dental emergencies.

The risk of harm from a dentist's failure to adhere to these requirements falls not on the dentist, but the patient. Enforcement of these requirements is necessary to protect the public health, safety and welfare. Accordingly, the sanction for violations of these

requirements should first be sufficient to ensure that the dentist possesses both the knowledge and the will to properly comply with the regulatory requirements, and second, to deter other dentists from non-compliance.

In prior matters involving failure to adhere to infection control requirements and emergency management regulations, the Board has imposed discipline against licensees owning dental practices that range from probation to suspension depending on the extent and duration of the failures. See, e.g., *In the matter of Dr. Frank T. Varinos*: DEN-2014-0090 (six month probation for failing to consistently spore test); *In the matter of Dr. Mark Zive*: DEN-2012-0050 & DEN-2012-0103 (one year probation for failing to conduct spore testing, *inter alia*), *In the matter of Dr. Jeffrey Lowenstein*: DEN-2012-0157) (one week suspension followed by one year probation for infection control violations); *In the matter of Dr. Theodore Souliotis*: DEN-2013-0210 & DEN-2014-0002 (six month suspension followed by six month probation for infection control violations, *inter alia*); and *In the matter of Dr. Robert I. Orenstein*: DEN-2016-0047 (indefinite voluntary surrender for infection control violations).

B. Respondent's Treatment of Patient A

As enumerated in the Tentative Decision, Respondent violated numerous regulations with respect to his treatment of Patient A, including several record keeping requirements. However, in fashioning the sanction, the Board's focus is on the Respondent's deviation from the accepted standard of care in his diagnosis and treatment recommendations with respect to Patient A. Specifically, the Respondent failed to utilize recognized and accepted diagnostic tests to assess the symptoms of pain in Patient A's tooth 19. Instead, the Respondent applied energy testing, as detailed in the Tentative

Decision at paragraphs 7 and 8, misdiagnosed Patient A as having an infection in the tooth, of a nature linked with development of cancer, which recommended treatment required a root canal or an extraction. Subsequent radiographs and evaluation showed that Patient A did not have an infection, but rather a hairline fracture, and that a root canal or an extraction of the tooth was inappropriate and not supported by the clinical evidence.

Prior matters before the Board involving allegations of substandard treatment chiefly focus on the inattention or negligence on the part of the dentist in approaching and applying the recognized standard of care. The dispute is not as to the applicable standard of care, but rather, whether or not the dentist in question met that standard. *In the matter of Dr. Paul Virgadamo*: DEN-2011-0114 and DEN-2011-0144 (six month suspension for failing over two years to diagnose decay in three teeth, among other violations); *In the matter of Dr. Italo Lozada*: DEN-2010-0171 (three month suspension followed by probation for failing to diagnose and properly treat severed lingual nerve arising from the licensee's treatment) and *In the matter of Dr. Brian Mangano*: DEN-2012-0027 (four month suspension followed by probation based on failing to expose radiographs for over 24 years, including radiographs before and after licensee's fabrication and placement of a bridge). In these cases, the matter in dispute was not as to the standard of care for examining and diagnosing patients but rather, whether it was met. In other words, the dispute was not *how* the dentist should properly examine and treat patients but *did* the dentist properly examine and treat a particular patient.

The present matter is markedly different. Respondent's position and earnestly held conviction throughout the hearing is that energy testing on a digital image of a tooth

is an appropriate means of diagnosing not only an infection of the tooth, but also the development of cancer. Moreover, the Respondent testified that results obtained by accepted diagnostic testing, i.e., palpation, cold air syringe test and mobility are "frankly meaningless" and have "limited diagnostic value". See Tentative Decision, ¶ 6(f). In other words, this is less a case of whether the Respondent correctly and diligently conducted accepted diagnostic testing, and more a case of whether the Respondent's energy testing diagnostic approach stands alongside accepted diagnostic testing. As detailed in the Tentative Decision at paragraphs 24–37, the Board finds that it does not, and, as detailed in the Tentative Decisions at paragraphs 15–19, that following application of energy testing, the Board finds Respondent made both an incorrect diagnosis and erroneous treatment recommendations.

Since the Board's prior matters more typically involve negligent application of the standard of care rather than frank deviation from the accepted standard of care, it takes guidance from the *Matter of Sara Stalman*, before the Board of Registration in Medicine, 0245-DALA (RM-02-1310)(June 16, 2004). Dr. Stalman was found to have treated patients under a diagnosis and treatment protocol which she developed. She used diagnoses that she invented that are not recognized by her peers in the practice of medicine. She made recognized diagnoses using diagnostic criteria that are not recognized by her peers. The Board of Registration in Medicine, consistent with its own prior decisions to remove physicians from practice for "substantial deviations in medical care and treatment," suspended Dr. Stalman indefinitely, with the possibility of staying the suspension after five years upon proof of completion of a Board approved clinical skills assessment program and a satisfactory psychiatric evaluation.

In keeping with its duty to promote the public health, welfare, and safety, and consistent with its prior rulings as applicable and the foregoing rationale, the Board issues the following order:

ORDER

The Board orders Respondent's license to practice dentistry in the Commonwealth suspended for no less than eighteen (18) months, commencing on the Effective Date of this Final Decision and Order ("Suspension Period").

Respondent may petition the Board for reinstatement of his license no sooner than 30 days prior to the end of the Suspension Period and upon demonstration that he has fulfilled each of the following conditions to the Board's satisfaction:

(1) Within thirty days of the Effective Date, Respondent shall provide a copy of this Final Decision and Order to all jurisdictions in which he holds or has held a license to practice dentistry.

(i) Respondent shall provide written documentation to the Board demonstrating his compliance with paragraph 1.

(ii) If Respondent is not licensed to practice dentistry in another jurisdiction, he shall submit a signed attestation to the Board stating such.

(2) Respondent shall successfully pass the Board's Jurisprudence and Ethics Examination within thirty days prior of submitting a petition for reinstatement.

(3) Complete a full day of Board-approved remedial continuing education in each of (a) interpreting radiographs, (b) diagnosis and treatment planning and (c) risk management. Such continuing education shall be pre-approved prior to registering for the courses and shall be attended in person and not taken as self-study or online.

(4) Respondent shall successfully pass the CDCA's Diagnostic Skills Examination OSCE; and successfully pass the CDCA's two

simulated clinical examinations, i.e., endodontic clinical examination and fixed prosthodontic clinical examination.

Upon receipt of Respondent's petition for reinstatement of his license, the Board shall require Respondent to appear before it.

During the Suspension Period, the Respondent shall comply with the additional conditions:

(5) Respondent shall not practice dentistry within the meaning of M.G.L. c. 112, §50.

(6) Respondent shall notify the Board in writing of any change to his address of record within seven (7) calendar days of such change.

(7) Respondent shall maintain patient records consistent with 234 CMR 5.14 and timely comply with all requests made by patients for their treatment records consistent with M.G.L. c. 112, § 12CC;

(8) Respondent shall not violate any provision of M.G.L. c. 112, §§43-53, 61 and 234 CMR.

(9) Commit any act that constitutes deceit, malpractice, gross misconduct in the practice of dentistry, unprofessional conduct, or conduct which undermines public confidence in the integrity of the profession.

(10) Respondent has the burden to prove compliance with the requirements of this Order and his Suspension.

If, during the Suspension Period, the Respondent fails to comply with any condition in paragraphs 5–10 above, the Respondent shall be entitled to a hearing as to whether he violated such condition. This hearing shall be conducted in accordance with the State Administrative Procedure Act, M.G.L. c. 30A, §§ 10 and 11 and the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 and 1.03 *et seq*. After a hearing, if the Board determines a violation did occur during the Suspension Period, it may impose a further sanction, deemed appropriate in its sole discretion. Such sanction

may include extension of Respondent's suspension or revocation of Respondent's license to practice dentistry in the Commonwealth.

The Board voted to adopt the Tentative Decision as its Final Decision at its meeting held on June 6, 2018, by the following vote:

In Favor:	Dr. Stephen C. DuLong, Ms. Kathleen Held, M.Ed., Ms. Stacy Haluch, RDH, Dr. Paul F. Levy, Dr. Michael A. Scialabba, Dr. Cynthia M. Stevens, Ms. Jacyn Stultz, RDH, and Dr. Patricia Wu.
Opposed:	None
Abstained:	None
Recused:	Ailish Wilkie
Absent:	Dr. John Hsu

On June 6, 2018, in accordance with the Board's authority and statutory mandate, the Board voted to issue this Final Decision and Order, by the following vote:

In Favor:	Dr. Stephen C. DuLong, Ms. Kathleen Held, M.Ed., Ms. Stacy Haluch, RDH, Dr. Paul F. Levy, Dr. Michael A. Scialabba, Dr. Cynthia M. Stevens, Ms. Jacyn Stultz, RDH, and Dr. Patricia Wu.
Opposed:	None
Abstained:	None
Recused:	Ailish Wilkie
Absent:	Dr. John Hsu

EFFECTIVE DATE

This Final Decision and Order ("Final Order") becomes effective upon the tenth (10^{th}) day from the date it is issued (see "Date Issued" below).

RIGHT OF APPEAL

Respondent is hereby notified of the right to appeal this Final Order to the Supreme Judicial Court within thirty (30) days of receipt of notice of this Final Order pursuant to M.G.L. c. 112, § 64 or by filing a claim for judicial review in Superior Court within thirty (30) days of receipt of notice of this Final Order pursuant to M.G.L. c. 30A, § 14.

DATE ISSUED: June 12, 2018

Barbara A. Young RDH

Barbara A. Young, RDH
Executive Director
Board of Registration in Dentistry

Notify:

By first-class and certified mail no. 7017 0530 0000 0551 5467, return receipt requested
Jeremy T. Robin, Esq.
P.O. Box 146727
Boston, MA 02114

By Interoffice mail
Beth Oldmixon, Esq.
Prosecutor
Department of Public Health
Bureau of Health Professions Licensure
239 Causeway Street
Boston, MA 02114

By Interoffice mail
Karen Gray Carruthers, Esq.
Administrative Magistrate
Department of Public Health
Bureau of Health Professions Licensure
250 Washington Street, 8th Floor
Boston, MA 02108

Exhibit A

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY BOARD OF REGISTRATION IN DENTISTRY

IN THE MATTER OF DAVID SATLOFF, DMD License No. DN 15101 License expiration date 3/31/2018	)	DEN 2012-0122; 2013-0178

TENTATIVE DECISION AFTER ADJUDICATORY HEARING

I. PROCEDURAL BACKGROUND

On April 17, 2015, the Board of Registration in Dentistry (Board) issued an Order to Show Cause to Respondent David Satloff, DMD (License No. DN 15101) why it should not suspend, revoke or take other action against his license to practice as a dentist or right to renew such license. The Order to Show Cause was amended on April 15, 2016. Respondent filed an answer to the amended Order to Show Cause on May 20, 2016. Respondent requested an adjudicatory hearing. I presided over such hearing in which evidence was presented on February 14-17, 27, March 3, 20, 31, April 3, 10 and 24, 2017. The hearing was audio-recorded. Dr. Satloff was present and represented by counsel.[1] Closing argument was held on August 16, 2017. Each side submitted post-hearing briefs, supplemental post-hearing briefs and response post-hearing briefs.

In this Tentative Decision, numbered paragraphs 1-127 represent findings of fact or determinations or law. Findings of fact are based upon a preponderance of the evidence.

I have considered all the evidence submitted whether or not it is referenced in this document. Evidence that is not contained in this document would not alter any findings of fact or legal determinations.[2] [3]

II. STATEMENT OF REASONS

1. On or about June 8, 1982, the Board issued Respondent a license to engage in the practice of dentistry, DN License No. 15101. (Stipulation 1) The license is current and due for renewal on March 31, 2018. (Stipulation 1) The Board has jurisdiction. See Wang v. Board of Registration in Medicine, 405 Mass. 15 (1989)

[1] Thirteen witnesses testified: Dr. Satloff; Dr. Paul Farsai; Kathy Eklund; Barbara Young; Lisa Seeley-Murphy; Barbara Yates; Patient A; Dr. Noshir Mehta; Dr. George Just; Roxanne Lewicki; Lauren McDermott Calvano; Patient D; and Patient E. A list of the sixty-five exhibits entered into evidence is found at the end of this decision.

[2] I received a transcript of the hearing. In parenthesis, numbers after testimony represent the transcript page number.

[3] In this document "accepted standards of care" and "recognized standards of care" are used interchangeably.

Respondent characterizes his practice as "a general dentist with a significant focus relating to pain issues." (Respondent Testimony at 964)

A. PATIENT A

2. On February 7, 2012, Respondent provided care and treatment to Patient A. (Stipulation 4) This was Patient A's first visit with Respondent and she was seeking to establish a relationship with a new dentist. (Patient A Testimony at 825) Patient A visited Respondent for a dental exam, teeth cleaning, and pain in a specific tooth. (Respondent Testimony at 1495-97; Patient A Testimony at 824-25, 832; Exhibit 6 at 1) Patient A signed a general consent form allowing tooth cleaning (tooth scaling and polish), photographs, and x-rays and for the dentist to evaluate her dental/medical health. (Exhibit 12 at 4-5)

3. Patient A told Respondent she had pain in the lower left first molar and pointed the tooth out to Respondent. (Patient A Testimony at 832-33) Respondent testified Patient A pointed out which tooth was hurting. (Respondent Testimony at 57-60) Prosecuting Counsel asserts Patient A's aching tooth was located on the lower left side of the mouth referred to by dentists as "tooth #19." (Dr. Farsai Testimony at 647; Exhibit 12 at 8) Respondent maintains the tooth was located on the lower right side of Patient A's mouth, and was tooth #30. (Respondent Testimony at 57-58, 70, 1497; Exhibit 12 at 8) Below at paragraphs 11-13, I find Patient A complained about tooth #19.[4]

4. Respondent exposed a periapical radiograph of Patient A's tooth #19. (Stipulation 14; Exhibit 13) No signs of infection could be seen on the radiograph. (Stipulation 15; Dr. Farsai Testimony at 674) Respondent or someone on his staff took a digital camera screen image of Patient A's paining tooth. (Respondent Testimony at 98; Patient A Testimony at 837)

5. Respondent failed to perform a wet or a dry cotton roll test on tooth #19 and failed to conduct an electronic pulp test on tooth #19. (Stipulation 18, 20)

6. Respondent testified in assessing Patient A's paining tooth he performed a palpation test, a percussion test, and a cold air syringe test (Respondent Testimony at 58, 1499-1501), but based upon the following, I find he performed no such tests.

    a. There is no record of a palpation test, percussion test or a cold air syringe test in Patient A's medical record. (Exhibit 12; Respondent Testimony at 1508-09, 1648-49; Dr. Just Testimony at 376-78)

[4] Respondent's references to tooth #30 during his testimony at the hearing have not been altered.

b. "There's an old rule that if you didn't write it down, it didn't happen." (Dr. Just Testimony at 326-27) and it cannot be assumed diagnostic tests were done where there are no notations in Patient A's medical record. (Dr. Farsai Testimony at 691)

c. Respondent's assertion he performed a palpation test, percussion test and a cold air syringe test as part of his initial exam is not supported.

1. There is a handwritten entry that states "initial exam." (Exhibit 12 at page 6) But a record stating initial comprehensive exam would not necessarily indicate percussion testing or cold air testing was performed because "an initial comprehensive exam takes into consideration the patient's medical history, dental history, radiographs, assessment of the radiographs, intra-oral examination, extra-oral examination, oral cancer screening, periodontal charting, and a full comprehensive exam. It's an intake exam." (Dr. Farsai Testimony at 672-73)

2. Further, while an initial exam could include palpation and other techniques not specifically included in the record and a dentist's assistant could testify as to the procedures the dentist "reasonably does on every patient" (Dr. Just Testimony at 376-78), Respondent's staff Lauren McDermott Calvano (Calvano) testified as to what Respondent's initial exam entailed but did not mention palpation, percussion or cold air syringe tests. She stated, "[u]sually it's charting existing, restorative work, needed work. Usually perio charting is done. It's a more involved examination than it would be just for like an every six-month kind of thing with a cleaning." (Calvano Testimony at 1154)

d. Patient A does not have a memory of Respondent performing a palpation test, percussion test, or a cold air syringe test but she recalls a subsequent dentist's testing two weeks later. As to her visit to Respondent's office, Patient A testified," "I don't remember there being any testing, other than the x-rays." On February 16, 2012, Patient A went to see endodontist Dr. Michelle Bento Lavall. (Exhibit 15 at 1-2) Patient A never had any problems with her teeth before and wanted a second opinion from a root canal specialist before having surgery [see below]. (Patient A Testimony at 860-61) Patient A complained about the same tooth to Dr. Lavall as she had to Respondent. (Patient A Testimony at 868) Dr. Lavall conducted various tests on the same side of Patient A's mouth involving hot and cold, biting on a stick and cotton. (Patient A Testimony at 861-63)

e. Respondent did not report to the Board on three opportunities during the

investigative stage he performed mobility or cold air tests when detailing his process in determining Patient A had unhealthy pulp. In only one submission did he mention performing a palpation test. (Exhibits 5-7)

f. Respondent testified the standard tests, including palpation, mobility or cold air, have "limited diagnostic value." When Respondent was asked why he did not record the required tests he responded, "Because the results of those tests are frankly meaningless..." (Respondent Testimony at 1509, 1648-49) Respondent was clear he relied on energy testing [discussed below] to make his diagnosis. When asked at the hearing, "And you determined that the vitality of the pulp was unhealthy, correct?" Respondent answered, "Not until I took a radiograph and did proteomic biomarker testing." (Respondent Testimony at 1503-04) In correspondence to the Board, Respondent stated he relied on energy testing for his diagnosis, "I stand by my diagnosis of an infected pulp based on the proteomic test and discovery of the presence of l-homocysteine in tooth 19." (Exhibit 6)

g. Even though Respondent testified Patient A expressed sensitivity when he percussed the tooth, he could not provide with certainty the results of any palpation, mobility or cold air tests. "I have a clear memory of the patient articulating about the sensitivity. I don't have a clear memory of palpation or mobility, so I can't provide testimony what her response was in relation to that. And my best recollection on blowing cold air was that she did indicate that she found that to be sensitive." (Respondent Testimony at 1648)

7. Respondent performed energy testing on either Patient A's radiograph or the digital image.[5] Relative to Patient A, Respondent performed the following types of "energy testing" in a back room adjacent to the examining room outside Patient A's presence.[6] (Respondent Testimony at 86-87, 129-30, 560-61, 568-76, 1192-1262; Exhibit 5)

   a. Applied Kinesiology (AK) - Respondent performed AK on the digital image by placing either a brass rod or his finger on the digital image on the area of the sensitive tooth he wanted to test. He then extended his arm outward and parallel to the ground and had his assistant push down on his arm. If the assistant was able to push down Respondent's arm,

[5] Prior statements and stipulations indicated Respondent performed the energy testing on the radiograph. At the hearing, Respondent testified the energy testing was performed on the digital camera screen image on the camera view finder. Whether energy testing was performed on the digital image and/or radiograph does not alter findings. Respondent's references to radiograph, digital image and/or digital camera screen image have not been altered.

[6] At the hearing Respondent and his dental assistant attempted to simulate the energy testing performed on Patient A. (Transcript at 1172-1282)

Respondent concluded the area on the image he was touching was infected or unhealthy.

b. Bi-Digital O-Ring Testing (BDORT) – Respondent states "BDORT is based upon the resonance phenomena in which substances of similar frequency will resonate with each other when placed in close contact with each other." Respondent placed his finger or a brass rod on the portion of the digital image he wanted to test. Respondent then extended his hand and formed an "O" by touching his thumb and finger together. His assistant then used her fingers to break apart the "O" while Respondent continued to touch the digital image. The O-Ring opened up where there is resonance. If the assistant was able to break apart the "O", Respondent found the area of the image he was touching to be infected or unhealthy.

c. Autonomic Resonance Testing (ART or resonance testing) – Respondent had a series of several hundred holographic slides called proteomic biomarkers. Respondent held a slide in his hand while touching the digital image and performing AK and/or BDORT as indicated above. Respondent continued this process with the various slides until a reaction occurred causing Respondent to quantify the levels of the biomarkers and determine the remedy for Patient A.

8. Using the following energy testing, Respondent determined the following regarding Patient A:

a. Respondent "used Dr. Yoshiaki Omura's patented Bi-Digital O-Ring Test (BDORT) only on [Patient A's] radiograph" to obtain the following results (Stipulation 33; Exhibits 5-7; Respondent Testimony at 1192-1262):

- "the major finding" was "blocked energy associated with [Patient A's] tooth 19." (Stipulation 30; Exhibit 6; Respondent Testimony at 1505);
- "[r]adiographic testing confirmed the presence of 1-homocysteine and integrinalpha5beta1 in the pulp of [Patient A's] tooth 19" (Stipulation 31; Exhibits 6,12); and
- "[t]he presence of 1-homocysteine protein…indicates that an infection is present in the tooth." (Stipulation 32; Respondent Testimony at 85-100)

b. Respondent performed additional energy testing on the digital image or radiograph using BDORT, ART and/or AK and found energy blockage

indicating the presence of bacteria requiring Zithromax. Respondent went through 30-40 bacterial slides and found there was a "resonance with both kinesiologic testing and with digital O-ring testing with a bacteria sensitive to Zithromax." Respondent expounded, "[w]henever there's pathogens living inside a root, that tooth is considered unhealthy. So the presence of bacteria and the presence of virus in the mesial root of tooth number 30 constituted an unhealthy tooth with an infection." (Respondent Testimony at 1505-06, 1511-12, 1757-58; Exhibits 5, 6, 12)

c. Respondent performed BDORT and applied kinesiology to determine Patient A "was positive for a virus HSV-2" and recommend she take MIC fish oil, a brand of fish oil he sells in his office. Respondent did not perform any other testing to conclude Patient A was positive for HSV-2. Respondent explained, "The label on MIC fish oil in 2012 indicated that in addition to Epstein-Barr virus, MIC fish oil resonates with HSV-2 virus, and because HSV-2 is very close in proximity, in frequency to HSV, we put down HSV-2 virus as the specific virus that was present in that mesial root of tooth number 30." Respondent further stated "Viruses -- well, first of all, other than myself, I don't know of any dentist who even checks for viruses. I do check for viruses. First I back-check with the remedy MIC fish oil, the patient's tooth. The mesial root resonated with this remedy, MIC fish oil. I then checked for the more common virus, which is herpes 4 virus which is Epstein-Barr virus, and I checked Epstein-Barr virus and it tested negative. In 2002 [sic] there was no slides to test for HSV-16 virus, so I put down the most likely cause that we found resonance for MIC fish oil which is HSV-2. HSV-2 and HPV-16 virus have very similar frequency so when we do resonance testing, it would resonate with MIC fish oil." (Respondent Testimony at 565-66, 568, 570, 589, 1651; Exhibit 5)

d. Using energy testing, Respondent found "the radiographic testing I performed showed the presence of alpha5beta1, which was found associated with tooth 19 is linked to the development of cancer." (Stipulation 46; Exhibit 6 at 4)

9. Prior to the start of her dental appointment with Respondent, Patient A completed a medical history form maintained in her medical record at Respondent's office. (Stipulation 38; Exhibit 12 at 17; Patient A Testimony at 827-28) In response to the medical history form inquiry, "Have you ever been hospitalized for any surgical operation or serious illness within the last five years? If yes, please explain", Patient A disclosed she had a [redacted] within the five (5) years prior to her February 7, 2012 treatment. (Stipulation 39; Exhibit 12 at 17; Patient A Testimony at 826-27) Regarding the [redacted] there is nothing in the medical history form indicating it was cancerous. (Exhibit 12 at 17)

10. Patient A testified Respondent told her she had the beginnings of cancer; if she did not have a root canal or extraction she would develop cancer; that "I needed to take an antibiotic and a fish oil, and that if I didn't have a root canal, then I would get cancer." (Patient A Testimony at 841-43; Exhibit 11 at 2) Respondent denies making such statements. (Respondent Testimony at 1755) Based on the following, I find Respondent told Patient A words to the effect she had the beginnings of cancer and if she did not have a root cancel or extraction she would develop cancer.

    i. Respondent testified the biomarkers he found "... in terms of bidirectionality, integrin alpha5beta1 and oncogene C-Fos 8beta2 are specific biomarkers that reflect cancer cell development related to the breast." (Respondent Testimony at 1653) Where Respondent testified a biomarker Patient A tested positive for was "related to the development possibly of pathology like cancer", it makes sense Respondent would provide this important information to his patient.

    ii. Although Respondent testified he did not use the terms "cancer" or "precancer" when speaking with Patient A and guessed he "talked about pathology" with her, he did not have a "specific memory." Further Respondent recollected he told his staff not to use the word "cancer", but later in his testimony, Respondent revealed he did use the word "cancer" in his discussion with Patient A by telling her the biomarker she tested positive for was "related to the development possibly of a pathology like cancer." (Respondent Testimony at 559-62, 1636-37, 1653-54)

    iii. Dental assistant Calvano, who was usually in the room when Respondent went over his findings with patients, testified in such situations Respondent "would probably say or he would usually say, I think it's L-homocysteine would be the biomarker for like cancer cells, not meaning you have cancer but, you know, you could be testing positive for precancer cells or what have you." (Calvano Testimony at 1166)

    iv. Respondent stated in a July 12, 2012 letter to the Board: "In fact, I felt it was my duty as a dental professional to inform Patient A that I had found proteomic biomarkers indicative of precancer associated with her sensitive and paining tooth so she could follow-up with her Primary Care Physician as soon as possible to prevent any future health issues. Had I not informed Patient A and, had she developed cancer at a later date, I would have felt that I did not act as a responsible medical professional." (Exhibit 6)

    v. Patient A was credible, emphatic, direct and unequivocal when testifying about statements Respondent made to her referring to cancer. Her testimony was consistent with the complaint she subsequently made to the Board.

1. On May 24, 2012, the Board received a complaint from Patient A which includes the statement, ""Dr. Satloff told me I need a root canal, that I had an infection. I was put on two medications that I took. He said I have the beginnings of cancer. I then went to an endodontic specialist. I was told that there wasn't an infection and I did not need a root canal." (Patient A Testimony at 844; Exhibit 11 at 2)

2. The complaint also states, "The [Respondent's] secretary told me that I should really do something with my tooth that I have cancer." (Exhibit 11 at 1)

3. Patient A testified her memory of her visit with Respondent was fresh in her mind when she made the complaint. (Patient A Testimony at 845) The date on the complaint is May 10, 2012 and dated stamped received by the Department of Public Health on May 24, 2012. (Exhibit 11 at 2)

4. Either on the same day or the day after her visit to Respondent's office, Patient A went to see another dentist, Dr. John P. Balamas. Patient A did not trust Respondent to do the root canal. Patient A told Dr. Balamas' nurse Respondent told her she would have cancer if she did not have a root canal. The nurse told Patient A she would get her an appointment for a checkup as quickly as possible. Respondent's statement to Patient A she possibly would have cancer caused her "great concern" which was only alleviated after Patient A saw other dentists. (Patient A Testimony at 864-70, 893; Exhibit 15 at 1)

vi. Patient A went back to Respondent's office to get her records. Patient A told the secretary at the front desk she would not be coming back and she wanted her records. The secretary told Patient A, "She said if I didn't do a root canal that I'd have cancer." (Patient A Testimony at 870-71; Exhibit 11 at 1)

vii. After Patient A left his office, on that same day of her visit, Respondent conducted further energy testing showing "nanograms of oncogene c-fosAB2 associated with tooth 19." (Stipulation 47, 49; Respondent Testimony at 606 and 1783-85) Respondent asserts "The presence of the oncogene confirmed my belief that precancer pathology was present and associated with tooth 19." (Stipulation 48; Exhibit 6 at 4)

11. An issue was whether Patient A was complaining about pain in tooth #19 (located on the lower left side of the mouth) or tooth #30 (located on the lower right side of the mouth). There is a radiograph of tooth #19 but there is no record of a

digital camera image being taken and/or retained. (Exhibit 12) Prosecuting Counsel maintains it was tooth #19.

12. Respondent's position that the paining tooth was #19 is summarized as follows. (Respondent Testimony at 98-100, 121-22, 169-172, 939, 1187, 1504-05, 1642-1643, 1665-66; Exhibit 13)

    a. "[W]ithout any doubt" the aching tooth was #30."

    b. Patient A pointed to her lower right first molar as the tooth that was hurting.

    c. Respondent told a staff member (unclear who) to take a radiograph of tooth #30; left the room to go to the bathroom and while he was out, a radiograph of tooth #19 was mistakenly taken.

    d. This mistake was entered into Patient A's medical record and carried forward.

    e. Either Respondent or someone on his staff took a digital camera screen image of tooth #30. He performed energy testing on the image of tooth #30.

    f. He tested, diagnosed and developed a treatment plan using the image of Patient A's tooth #30 - not tooth #19.

    g. He became aware of the error in fall 2016 after reviewing the radiograph of tooth #19. (Exhibit 13)

13. For the following reasons, I find Patient A complained about pain in tooth #19 not tooth #30, and imaging (whether radiograph and/or digital camera) was of tooth #19.

    a. Patient A testified convincingly her paining tooth was the second molar from the back on her left side (tooth #19). (Patient A Testimony at 832)

    b. No reason was provided as to why Patient A would not correctly identify which tooth in her mouth was aching. Tooth #19 and tooth #30 are on different sides of the mouth; the likelihood of confusion seems remote. Tooth #30 is a "virgin tooth" while tooth #19 has a mercury restoration. (Respondent Testimony at 92, 939; Dr. Farsai Testimony at 647; Exhibit 12 at 7)

    c. Respondent agreed such teeth would be easily distinguishable on a digital image from one another. (Respondent Testimony at 178-79)

    d. The radiograph states teeth ##18, 19 and 20. (Exhibit 13)

e. All of Patient A's records from her visit to Respondent's office refer to tooth #19 as the hurting tooth. (Exhibit 12)

f. There are no references to tooth #30 as the hurting tooth in Patient A's record. (Respondent Testimony at 1824; Exhibit 12)

g. Respondent handwrote tooth "#19" at least three times in Patient A's record including on the patient screening sheet which he reviewed with Patient A. (Exhibit 12 at 6 and 9; Respondent Testimony at 90, 549-50)

h. February 16, 2012 records from Dr. Lavall for Patient A refer to tooth #19 and state "#19 Consult for RCT Treatment." (Exhibit 15 at 1, 2 and 6)

i. February 21, 2012 records from Dr. Balamas for Patient A refer to tooth #19 and note testing on tooth #19. (Exhibit 15 at 4 and 5)

j. That Patient A would mistake both the tooth and which side of her own mouth was aching is incredible especially where there is documentation from visits to another dentist and an orthodontist just days after seeing Respondent corroborating Patient A's painful tooth was #19.

k. Respondent provided a transcript of Patient A's record to the Board repeatedly referencing tooth #19. (Exhibit 12 at 15; Respondent Testimony at 69-70)

l. In a December 18, 2013 affidavit Respondent states "...I took a radiograph of [Patient A's] tooth 19" and performed resonance testing. He later states, "I then checked the radiograph at and around tooth 19..." (Exhibit 5)

m. In a July 12, 2012 letter to the Board, Respondent states Patient A came to his office "complaining of sensitivity and pain in the area of tooth 19." Respondent states he did "radiographic testing" on "tooth 19" and continues to describe procedures and diagnosis referring to "tooth 19" more than a dozen times. (Exhibit 6)

n. In a December 9, 2013 letter to the Board Respondent states, "The only testing I performed on [Patient A] for tooth 19 was palpation and one periapical radiograph." (Exhibit 7) I reject Respondent's testimony the references to radiographic testing and tooth #19 in his December 9, 2013 letter are incorrect. (Respondent Testimony at 113-16)

o. It is implausible an experienced dentist such as Respondent and his staff

continued to incorrectly refer to tooth #19 throughout Patient A's record as well as in multiple subsequent narratives submitted to the Board. Respondent's emphatic assertion he now has a clear memory of Patient A complaining about the lower right side of her mouth five years after the dental appointment rings hollow.

14. Respondent documented the following in Patient A's record: "#19 sensitivity"; "1-homocystiene 1.0 mg."; "integrin 36ng"; "⊕ bacteria → Z-pak"; and "⊕ HSV_2 → Mic 5X10". (Stipulation 7; Exhibit 12) There is no documentation of the testing or diagnosing technique used to make these determinations. (Exhibit 12)

15. Respondent told Patient A she had an infection in her tooth. (Stipulation 22; Patient A Testimony at 841) and needed a root canal or an extraction. (Patient A Testimony at 841-48; Exhibits 6, 12) "I informed the patient that when you have an unhealthy pulp, you need intervention and appropriate intervention would be either RCT [root canal therapy] or extraction." Respondent told Patient A one option was to do nothing but the infection may return. (Respondent Testimony at 574, 1660-61)

16. Respondent prescribed Patient A a "Z-pak" to treat an infection in tooth #19. (Stipulation 24) Respondent told Patient A she needed to take an antibiotic [Z-pak] to treat the infection in her tooth and fish oil. (Patient A Testimony at 841; Respondent Testimony at 564-65, 570-71, 1216, 1236-37, 1757-58)

17. There is no documentation of the diagnosis or medical justification for prescribing Patient A a Z-pak or MIC fish oil. (Exhibit 12)

18. Patient A's tooth #19 did not have unhealthy pulp; and there was no reason for root canal therapy or extraction. (Dr. Farsai Testimony at 677-79, 696-97)

    a. The periodontal pocket probing depths around tooth #19 was two millimeters. (Exhibit 12 at 8) A normal tooth probing depth is one to three millimeters. (Dr. Farsai Testimony at 677; Dr. Just Testimony at 266) Although Patient A's medical record with Respondent show recordings of the probing depths on three sides - as opposed to four plus sides called for by standard of care (Dr. Farsai Testimony at 676-78; Dr. Just Testimony at 344-45; Exhibit 12) - I credit Dr. Farsai's testimony the probing results for tooth #19 indicate "a very healthy tooth." (Dr. Farsai Testimony at 676-77)

    b. When Patient A visited Dr. Lavall, Dr. Lavell took x-rays. Dr. Lavell concluded Patient A had a hairline fracture but she did not have an infection nor did she need a root canal. Dr. Lavall recommended Patient A have her tooth capped. Patient A had her tooth capped four years later. (Patient A Testimony at 861-63)

19. Respondent maintained a medical record of Patient A's appointment. (Exhibit 12)

Patient A's records included forms with handwritten entries by Respondent or his assistant at the time of Patient A's visit or shortly thereafter on the same day. Respondent identified the handwritten notations and abbreviations in Patient A's record. (Respondent Testimony at 76-94, 550; Exhibit 12).

20. In Respondent's record of Patient A, there is no:

a. result of a comprehensive clinical examination of the head and neck (Exhibit 12);

b. dated written or electronic signature by dentist or dental auxiliary who treated Patient A (Stipulation 6; Exhibit 12);

c. record of an intraoral cancer screening being performed (Dr. Just Testimony at 345-46; Exhibit 12; Respondent Testimony at 138-39);

d. documentation of energy testing including AK, BDORT ART (Exhibit 12; Respondent Testimony at 1521);

e. documentation of negative results from energy testing (Calvano Testimony at 1156-57; Respondent Testimony at 1771-72; Exhibit 12);

f. documentation of findings of "nanograms of oncogene c-fosAB2 associated with tooth 19" or the testing or diagnosing technique used to make that determination (Stipulation 47; Respondent Testimony at 1783-85; Exhibit 12);

g. no documentation of examination of the radiograph of teeth #18-20 (Exhibits 12-13; Farsai Testimony at 647, 693);

h. findings of a digital image examination (Exhibit 12);

i. record of a digital image being taken nor was a digital image or digital camera screen image retained (Respondent Testimony at 98-99, 116; Exhibit 12);

j. findings concerning an intra-oral or extra oral examination (Exhibit 12; Dr. Farsai Testimony at 693);

k. record of joint or cranial testing (Dr. Just Testimony at 344-45); and

l. additional information concerning Patient A's disclosure [redacted] (Exhibit 12; Respondent Testimony at 595-96)

21. Each side offered a proposed expert witness. Prosecution offered Dr. Paul Farsai while Respondent offered Dr. George Just. I found each is an expert in the standards of care applicable to general dentists based on the following.

a. Regarding Dr. Farsai, he: (i) received his DMD in 1994 and Certificate of Advanced Graduate Study in Advanced Education in General Dentistry Residency in 1995 from Boston University Goldman School of Dental Medicine; (ii) earned a Master of Public Health in 1997 from Boston University School of Public Health; (iii) underwent a two-year faculty training fellowship in geriatric dentistry and medicine sponsored by the United States Department of Health and Human Services/Bureau of Health Professions from 1995-1997; (iv) has been licensed in Massachusetts as a dentist since 1994; (v) has been in private practice as a full-time general dentist since 1997 and has been an expert consultant in dental cases approximately 30 times; (vi) is an associate professor at Boston University Dental School and directs the program on behavioral sciences and evidenced-based dentistry; (vii) is a member of numerous professional organizations and honor societies and has published articles in dentistry peer-reviewed journals including the Journal of the American Dental Association; and (viii) is a member and panelist of the Center For Evidence-Based Dentistry at the American Dental Association. (Dr. Farsai Testimony at 627-47; Exhibit 8)

b. Regarding Dr. Just, he: (i) received his DDS from Case Western University of Dentistry in 1973; (ii) received a Graduate Certificate in Endodontics from New York University – Peninsula Hospital Care in 1977; (iii) has an active dental license in Pennsylvania and has inactive licenses in New York, Connecticut and New Jersey; (iv) his work experience includes a private dental practice since 1977 with a specialty practice in endodontics; (v) performed 40,000 procedures involving root canals; (vi) has been a lecturer for Dentsply International, Tulsa Endodontic Division since 1988; (vii) has been associated with the University of Pittsburgh School of Dentistry, Department of Restorative Dentistry (Endodontic Division) in various faculty positions since 1991; (viii) has been the President of the East Suburban Dental Society (a branch of the Pennsylvania Dental Association organization associated with the American Dental Association) for approximately twenty years; and (ix) served as a reviewer for the *Journal of the American Dental Association* 1995-1997. (Dr. Just Testimony; Exhibit 18)

22. I found neither Dr. Farsai nor Dr. Just is an expert in energy testing, BDORT, AK or ART. I addressed this in the July 17, 2017 Order regarding Dr. Just and the principles are equally applicable to Dr. Farsai. That neither Dr. Farsai nor Dr. Just is an expert in energy testing, BDORT, AK or ART does not bar either from (a) opining as to the recognized standards of care for general dentists; (b) opining whether energy testing, BDORT, AK or ART fall within the recognized standards

of care for general dentists; and (c) opining whether Respondent acted in accordance with the recognized standards of care for general dentists. But because neither is an expert in energy testing, BDORT, AK or ART, I have given no weight to any testimony or exhibits (even documents both parties agreed should be entered in evidence) regarding such persons regarding the efficacy or lack thereof of energy testing, BDORT, AK and ART.

23. While recognized standards of care is "always evolving" (Dr. Just Testimony at 254-55), Respondent's use of energy testing to diagnosis, and treat Patient A's tooth #19 violates recognized standards of care applicable to general dentists. I based this finding on the following detailed in paragraphs 24-37.

24. American Dental Association policy requires an evidence based approach to oral health and diagnostic and treatment. "The ADA supports the scientific exploration needed to discover new diagnostic and treatment approaches and techniques and encourages advocates of unconventional dentistry to pursue scientifically valid, systematic assessment of diagnostic and treatment efficacy and safety." (Exhibit 17)

25. Accepted standards of dental practice oblige general dentists in determining whether a root canal is necessary to conduct an intake examination, perform diagnostic tests; review radiographs for a lesion on a particular tooth and obtain information from the patient. Accepted standards of dental practice oblige general dentists in determining whether an extraction is appropriate to first determine if a root canal is necessary and then provide extraction as an option for a patient that does not want or cannot afford a root canal. (Dr. Farsai Testimony at 674-76, 751) Accepted standards of care for general dentists to determine a patient needs antibiotics involve visual inspection of soft tissue with swelling or infection, swelling with the palpation test, infection on the radiograph or as determined by deep pocket probing. (Dr. Farsai Testimony at 673-74, 694-95; Exhibit 8 at 3)

26. General dentists acting within the recognized standards of care use an algorithm to diagnose the cause of a paining tooth and develop a treatment plan. The process is like a flow chart with decision trees depending on answers from the patient and tests results. The algorithm includes a radiograph assessment (periapical tissue and periodontal ligament space can be examined for any signs of inflammation), inquiring of the patient when the pain exists and sensitivity, performing a wet and dry cotton roll test (patient bites down on a cotton roll (wet and/or dry), a percussion test (gently tapping the various cusps of teeth in the quadrant with a blunt instrument to determine marked sensitivity), a palpation test, electric pulp test, cold ice chip test and/or cold air spray test. Not every one of these tests is necessarily needed in a particular case to be performed to fall within the recognized standards of care for diagnosing the health of pulp tissue. (For example, Dr. Just testified electric pulp test is "relatively inaccurate" and tooth sleuth is more accurate than the cotton roll test. The diagnostic tools take

place sequentially and methodically.) Recommended standards of care for positive results would be to prepare the tooth for a temporary crown placement to further determine if sensitivity goes away with the temporary crown or whether it lingers. If sensitivity goes away, the full coverage temporary crown is preventing the tooth from flexure and the procedure can be completed with a permanent crown. It can take several weeks to come to this conclusion of the diagnosis. If the tooth is still sensitive to chewing even with the temporary crown, this is an indication a crack has propagated too close to the pulp and requires a root cancel therapy procedure. (Dr. Farsai Testimony 657-672, 708-10; Exhibit 8 at 2; Dr. Just Testimony at 261, 282-83, 275)

27. Energy testing (AK, BDORT, and/or ART) is not within the accepted standards of care for general dentists. (Dr. Farsai Testimony at 687-690; Exhibit 8 at 4-5) Accepted standards of care requires procedures be subject to clinical trials, studies and peer reviewed; there is no documentation these processes occurred with energy testing. (Dr. Farsai Testimony at 727-28, 748-51,761-62) Dr. Farsai is not aware of any documentation showing BDORT[7] in dentistry was a "scientifically valid systematic assessment." Dr. Farsai does not know any dentist that uses BDORT. Dr. Farsai reviewed documents provided by Respondent and noted the information provided no references to the specific procedures Respondent performed on Patient A's image using energy testing. (Dr. Farsai Testimony at 721, 756-57, 761-62) A diagnosis of "blocked energy" is not a diagnosis for tooth pain under the accepted standards of dental practice. (Exhibit 8 at 2)

28. Diagnosis of the presence of biochemical products require a sample of a lesion, blood or pulpal tissue (physically assessed) be sent to a laboratory for evaluation. (Dr. Farsai Testimony at 688-90; Exhibit 8 at 3) "There is no testing on an image. That does not exist in today's standard of care." A general dentist acting within the accepted standards of care cannot diagnose from a radiograph or digital image of a tooth L-homocysteine, integrim alpha5beta1, HSV-2, integrin alpha5beta1, or C-reactive protein in a radiograph or digital image. (Dr. Farsai Testimony at 687-90, 769)

29. Written articles and/or other energy testing documents provided by Respondent fail to demonstrate energy testing is within the accepted standards of care for general dentists. The articles were not peer reviewed and/or did not involve dentistry and the procedures Respondent performed on Patient A. (See Exhibits 24-39, 42-51) The patent document entitled "Bidigital O-Ring Test For Imaging And Diagnosis Of Internal Organs Of A Patient" has figures showing B-DORT performed on a human being, not an image. (Exhibit 57; see also Dr. Farsai Testimony at 729-34) Although Respondent notes a 1988 affidavit from a Dr.

[7] Energy testing, BDORT, AK and ART were often used interchangeable in testimony and exhibits. At times witnesses or documents do not specify whether the reference is to energy testing as a whole or BDORT, AK or ART individually or collectively.

Joel Friedman in support of the patent stating B-DORT "can be used in almost every specialty of medicine, as well as dentistry" and "can localize most of the temporo-mandibular joint problems in addition to the causes of facial oral pain and location of the infection, as well as the selection of effective antibiotics," no scientific documentation supporting these claims were provided in the document nor was evidence presented demonstrating there have been peer reviewed studies on energy testing in dentistry in the 30 years since. (Exhibit 31; Dr. Farsai Testimony at 750-51)

30. Respondent's position BDORT and AK are quantifiable because of the use of slides with proteomic biomarkers (Respondent Testimony at 1684) was not verified. Respondent testified "the use of bidigital O-ring testing has both state approval and state accreditation" in New York and other states and "in Massachusetts the use of applied kinesiology has approval and accreditation by the division of licensure." (Respondent Testimony at 959, 1473) Evidence verifying the assertions (including the type of energy testing, whether it was applicable to dentistry and/or whether the procedures were those used by Respondent on Patient A) was not presented.

31. Respondent testified the Board accepted all of his continuing education credits including at least one course on energy testing, (Respondent Testimony at 1060-61), but the Board's dental license renewal process only involves a dentist attesting he is in compliance with all Board regulations, state laws, and ordinances, essentially attesting he fulfilled the required continuing education hours; dentists are not required to submit continuing education certificates. (Young Testimony at 1797-1801)

32. I adopt in full Dr. Farsai's testimony regarding Respondent's use of energy testing to diagnose and treat Patient A not falling within the accepted standards of care for general dentists because his testimony on such was credible, supported, and consistent with the facts. In contrast, Dr. Just's opinion (Dr. Just Testimony at 288) Respondent's use of energy testing on Patient A was within the accepted standards of care for general dentists is not supported or consistent with the facts.

33. A central pillar in Dr. Just's opinion regarding Respondent's use of energy testing on Patient A is contrary to the facts. Dr. Just opines energy testing can be used as an adjunct with more traditional tests. (Dr. Just Testimony at 275-76, 288-89) He "certainly would not use it as a sole test and say, hey, I am going to do root canal therapy on this tooth because it flunked the biomarker test." (Dr. Just Testimony at 275)

34. When asked if the energy testing Respondent performed on Patient A fell below the standards of care for a general dentist, Dr. Just testified, "Well, considering that he [Respondent] also did a percussion test and did a cold test with air in this particular case and had an inclination that the tooth had an issue, because the patient was complaining of discomfort, this would be more of an adjunct. I don't

think it's a breach of the standard of care when you use these other tests." (Dr. Just Testimony at 275) But as demonstrated above, Respondent solely relied upon energy testing in diagnosing and treating tooth 19. Dr. Just based his conclusions of Respondent's diagnosis and treatment of Patient A on what was in Patient's A record and what Respondent told him he did with respect to Patient A. His understanding Respondent conducted percussion and cold air tests comes from his reliance on Respondent's statements, as documentation of these procedures being performed are not in Patient A's record. (Dr. Just Testimony at 342-43, 371-72) While Dr. Just may not be faulted for his erroneous understanding, the central pillar of his opinion is faulty and that alone substantially impairs his standards of care opinion regarding Respondent's diagnosis and treatment of Patient A.

35. Further, Dr. Just's opinion that energy testing is within the standards of care for general dentists when used as an adjunct procedure is not supported by evidence. Although he point out there is no ADA position statement indicating energy testing is unacceptable, he acknowledged energy testing does not have long-term studies comparing it to other diagnostic modalities; energy testing's potential rate of error and scientific techniques have not been published or examined; and he has not seen a study indicating whether energy testing received general acceptance in the dental community. While Dr. Just testified energy testing received general acceptance in the dental community for muscle testing and joint testing, he did not so testify in the context of diagnosing pulp on an image. Dr. Just uses energy testing in his practice to determine malfunctions of the masticatory system, bite and related muscle strength in possible diagnosis of TMD and TMJ but does not use them to test for disease in tooth pulp. He explained why he does not use energy testing to test for disease in tooth pulp. "I don't use it as a test for disease in pulp, and the reason I don't use it is probably because of the reason we're here. It is not widely accepted by state boards and I just don't want to have any grieve [sic] and aggravation." "As I said, it's not a commonly accepted practice." "It's a question of that state boards are very conservative and I am not personally willing to have to face a challenge to defend myself. I believe it's a very important branch that will evolve more and more into general practice and specialty practice..." When asked if he used BDORT or proteomic biomarker testing to test the disease in the pulp of a tooth Dr. Just testified, "But I would not do that on a regular patient because the Board would get possibly distraught about that situation and I don't need that involvement." (Dr. Just Testimony at 221-22, 233, 247, 369, 380-86)

36. Respondent has a long-held belief in the efficacy of energy testing and opened his dental practice because, he "wanted to bring dentistry into the 21st Century (Respondent Testimony at 963); but Respondent's belief does not make energy testing compliant with recognized standards of care for general dentists.[8]

[8] I detail the genesis of Respondent's interest in energy testing in paragraph 122. I detail what Respondent believes he can accomplish with energy testing in paragraph 123.

37. Similarly, while certain patients of Respondent's and certain of his staff believe in the efficacy of energy testing, such anecdotal evidence does not make energy testing compliant with recognized standards of care for general dentists.[9]

Violations Relevant to Patient A

38. Respondent violated 234 CMR 5.15(2) which requires maintenance of patient records that are legible and clear in meaning to a subsequent examining or treating dentist, the patient, dental auxiliaries or other authorized persons. Patient A's record had indecipherable handwritten notations, unclear abbreviations and the inability for a subsequent reviewer to determine procedures performed, results and/or treatment options. Dr. Farsai could not read some of the handwriting in Patient A's chart, did not understand some of the notations including "MIC", could not determine what procedures were performed and/or the results or treatment options. (Dr. Farsai Testimony at 651-52, 664-67, 678) Respondent's rationalization subsequent dentists could call and get additional information from him if needed (Respondent Testimony at 1781-82, 1813) is immaterial.

39. Respondent violated 234 CMR 5.15(3)(c)(1) which requires documentation in a patient's records of the results of a comprehensive clinical examination of the head and neck. Patient A's record is devoid of the results of a comprehensive clinical examination of the head and neck.

40. Respondent violated 234 CMR 5.15(3)(c)(5) which requires documentation in a patient's record of the results of a comprehensive clinical examination of an oral cancer screening. Respondent violated this regulation as Patient A's record is devoid of the results of an oral cancer screening.

41. Respondent violated 234 CMR 5.15(3)(d) which requires documentation in a patient's record of the written diagnoses of a patient's current dental status based on radiographic findings. Respondent violated this regulation by not basing his written diagnosis on the radiographic findings even though he took a radiograph of teeth 18-20.

42. Respondent violated 234 CMR 5.15(3)(g)(2) which requires including a statement of services provided including procedures performed and diagnoses. Respondent failed to document his use of the procedures performed (i.e. use of energy testing).

43. Respondent violated 234 CMR 5.15(3)(g)(5) because Patient A's records do not include a dated written or electronic signature of Respondent or his staff.

[9] I detail what such patients and staff state regarding Respondent and energy testing in paragraphs 124-27.

44. Each violation in paragraph 38-43 is a violation of a duty or standard depicted in 234 CMR 5.15 and subjects Respondent's license to discipline by the Board pursuant to 234 CMR 9.05(2) for violating duties and standards set out in 234 CMR.

45. Respondent's violation of 234 CMR 5.15(2), 234 CMR 5.15(3)(e)(1), 234 CMR 5.15(3)(c)(5), 234 CMR 5.15(3)(d), and 234 CMR 5.15(3)(g)(2) each:

    a. undermines the public's confidence in the integrity of the dentist profession subjecting his license to discipline by the Board pursuant to 234 CMR 9.05(1) and pursuant to the cognate common law prohibition against so undermining expressed in Sugarman v. Board of Registration in Medicine, 422 Mass. 338, 342 (1996) ("Sugarman principle"); and

    b. subjects his license to discipline by the Board pursuant to 235 CMR 9.05(8) for engaging in conduct that places public health, safety or welfare at risk.

46. Each of the following violations subjects Respondent's license to discipline by the Board pursuant to 234 CMR 9.05(14) and pursuant to the malpractice in the practice of the profession prong within G.L. c. 112, § 61 for committing an act that violates recognized standards of care. There is a relationship between recognized standards of care and the malpractice prong within G.L. c. 112, § 61. See Fitzgerald v. Board of Registration in Veterinary Medicine, 399 Mass. 901, 904-05 (1987))

    1. Accepted standards of dental practice oblige general dentists to document in the record everything they do on a patient. (Dr. Just Testimony at 342-49; Dr. Farsai Testimony 649-52) Respondent failed to include procedures performed (i.e. energy testing) in the statement of services.

    2. Respondent did not maintain the digital image. Digital images are part of a patient's record and should be stored electronically as part of patient's record under recognized standards of care. (Dr. Farsai Testimony at 654-56, 766)

    3. Respondent's use of procedures (i.e. energy testing) that do not fall within the recognized standards of care for general dentists to examine, diagnose and treat Patient A violate recognized standards of care.

47. Respondent's use of procedures (i.e. types of energy testing) that do not fall within recognized standards of care for general dentists to examine, diagnose and

treat Patient A subjects his license to discipline by the Board on each of the following independent grounds:

a. undermines public confidence in the profession's integrity (234 CMR 9.05(1); Sugarman principle);

b. pursuant to 234 CMR 9.05(8) for conduct that places public health, safety or welfare at risk;

c. pursuant to 234 CMR 9.05(20) because he prescribed Zpak without conducting an appropriate dental examination;

d. pursuant to 234 CMR 9.05(1) for unprofessional conduct;

e. pursuant to 234 CMR 9.05(1) for engaging in misconduct in the practice of dentistry by demonstrating a lack of concern for one's conduct (See Hellman v. Board of Registration in Medicine, 404 Mass. 800, 804 (1989); and

f. pursuant to the gross misconduct prong within G.L. c. 112, § 61 because it is intentional flagrant and extreme wrongdoing in the practice of the profession. (See Hellman, 404 Mass. at 804)

48. Respondent's informing Patient A she had the beginnings of cancer based upon his use of energy testing subjects his license to discipline by the Board on each of the following independent grounds:

a. undermines public confidence in the profession's integrity (234 CMR 9.05(1); Sugarman principle);

b. pursuant to 234 CMR 9.05(8) for conduct that places public health, safety or welfare at risk;

c. pursuant to 234 CMR 9.05(14) for committing acts that violate recognized standards of care;

d. pursuant to the malpractice in the practice of the profession prong within G.L. c. 112, § 61; (See Fitzgerald, 399 Mass. at 904-05);

e. pursuant to 234 CMR 9.05(1) for unprofessional conduct;

f. pursuant to 234 CMR 9.05(1) for engaging in misconduct in the practice of dentistry by demonstrating a lack of concern for one's conduct (See Hellman, 404 Mass. at 804); and

g. pursuant to the gross misconduct prong within G.L. c. 112, § 61 because it is intentional, flagrant and extreme wrongdoing in the practice of the profession. (See Hellman, 404 Mass. at 804)

49. Each violation of a Board regulation noted in paragraphs 38-48 subjects Respondent's license to discipline by the Board under the offense against laws prong of G.L. c. 112, § 61. (See Giroux v. Board of Dental Examiners, 322 Mass 251, 252 (1948))

Non-Violations Relevant to Patient A

50. Respondent did not violate 234 CMR 5.15(3)(b)(1). This regulation requires documentation of a patient's medical and dental history in the patient's records. Patient A completed a medical history form on which she stated "[redacted]". Respondent asserts he discussed the [redacted] with her for at least 10 minutes but did not document it. If Respondent had such a conversation, medical details concerning it should be in the record. They are not. But I find Respondent did not have such a conversation. Respondent could not remember details of the purported conversation including whether he asked if a [redacted] if Patient A was undergoing treatment or if there was a finding of cancerous cells. (Respondent Testimony at 601-02, 1652) Patient A testified credibly the [redacted] determined it was non-cancerous and she did not discuss this procedure with the Respondent or his staff. (Patient A Testimony at 831-32) If Respondent had such a conversation he would have realized the non-cancerous nature of the cyst, but in a July 12, 2012 letter to the Board wrote - "Knowing that [Patient A] has had prior issues with cancerous cells indicates that she would be at a higher risk for future issues with cancerous cells than an individual with no previous history of cancerous issues." (Exhibit 6 at 4)

51. Respondent did not violate 234 CMR 5.15(3)(b)(4) which requires documentation of consultation with the patient's medical physician(s) as appropriate. Respondent did not consult with any medical physician concerning Patient A. (Exhibit 12; Respondent Testimony at 917-18) Respondent did not violate this regulation.

52. Respondent did not violate 234 CMR 5.15(3)(c)(7) which requires documentation in a patient's record of the results of any other examination performed by the licensee and/or dental auxiliary as necessary and appropriate to facilitate comprehensive diagnosis of the patient's dental status. Respondent solely performed energy testing relative to Patient A. Because energy testing is not "necessary and appropriate to facilitate comprehensive diagnosis of the patient's dental status", Respondent has not violated this regulation.

53. Respondent did not violate 234 CMR 5.15(3)(c)(8) which requires documentation in a patient's record of the results of a comprehensive clinical examination including findings which are within or outside normal limits. Because there is no evidence regarding energy testing having "normal limits", Respondent's failure to document this energy testing does not constitute a violation of this regulation.

54. Respondent did not violate 234 CMR 5.15(3)(e) which requires documentation of a written treatment plan describing in detail in the proposed treatment. Patient A's records included prescribing MIC fish oil and Z Pak and the need for either root canal or extraction of tooth #19. Patient A's records also include the cost for a root canal or extraction. (Exhibit 12 at 18) There is no violation of this regulation.

55. Respondent did not violate 234 CMR 5.15(3)(f)(1) which requires documentation of a patient's general informed consent allowing the dentist to examine, diagnose and treat the patient. Prosecuting Counsel argues Respondent failed to obtain Patient A's consent to perform energy testing. Patient A signed a general consent form allowing the taking of photographs and x-rays. Dr. Just testified once consent is obtained from a patient to take an image (radiograph or digital camera) no additional consent is required for energy testing on that image because there is no physical touching of the patient. (Dr. Just Testimony at 290, 354-61) While Dr. Farsai testified a dentist must obtain consent on all tests performed on a patient and gave examples of specific procedures such as a biopsy or extraction, he did not provide a specific opinion as to energy testing on an image. (Dr. Farsai Testimony at 766-72) Respondent did not violate 234 CMR 5.15(3)(f)(1).

56. Respondent did not violate 234 CMR 5.15(3)(g)(4) which requires documenting referral for specialty treatment because Respondent referred Patient A to her primary care physician and not to a specialist. On the patient screening sheet, there is a section title "Referral" with options to check off Oral Surgery, Endodontist, Implants, Physician or Other. There is a handwritten "x" on the line for Physician. (Exhibit 12 at 9) Respondent referred Patient A to her primary care physician via the screening sheet he provided her during her visit. While Patient A was sitting in the examination chair, Respondent reviewed the results of the examination with her and provided Patient A with a patient screening sheet which had the results of his testing. (Respondent Testimony at 136, 547-48, 1522-32; and 1630-31; Patient A Testimony at 850-52; Exhibit 12 at 9)

57. Respondent did not violate 234 CMR 5.20 or 234 CMR 9.05(17) because the record does not establish Respondent violated established ethical standards of the profession as to his treatment, diagnosis or documentation relative to Patient A.

58. The record does not establish Respondent violated accepted standards of care relative to explaining to Patient A how he came to his diagnoses. Accepted standards of dental practice oblige general dentists to explain to patients how they came to their conclusions. (Dr. Just Testimony at 358-59) Respondent did not document explaining his diagnostic techniques and results to Patient A. (Exhibit 12) Respondent and Patient A differ regarding whether she was informed energy testing was utilized in making his diagnoses. (Patient A Testimony at 823-24, 829-30, 841-843 and 853; Respondent Testimony at 136-37, 1522-24) But, Respondent went over the patient screening sheet (Exhibit 12 at 9) in detail on how he got the results, asked if she understood what he was saying and she

indicated she did, and Respondent does not recall any follow-up questions. (Respondent Testimony at 1526-27)

59. Scaling is different than polishing. (Respondent Testimony at 175-76) Respondent testified he performed all scaling himself for Patient A's visit. (Respondent Testimony at 172, 1501, 1537) Dental assistant Calvano testified although staff may polish teeth only Respondent scaled teeth. (Calvano Testimony at 1133-34) Respondent testified he scaled Patient A's teeth but does not know who polished them. (Respondent Testimony at 58, 172) Patient A testified a woman did the "cleaning" but she could not recall any of the tools used. (Patient A Testimony at 839, 883) There is no patient record of who scaled, cleaned and/or polished Patient A's teeth. (Exhibit 12) The record does not establish Respondent allowed an unlicensed practitioner to scale Patient A's teeth.

B. MAILING

60. On or about September 29, 2013, Respondent's staff, at his direction, sent a mailing to residents in a five to ten mile radius from the Seekonk office. The material was also used at open houses held by the Respondent. (Calvano Testimony at 1147-48 and 1162-63; Exhibit 14) The mailing was sent to Patient B (a minor) but was intercepted by her mother, Patient A. (Patient A Testimony at 825, 871-73, 877, 887-90)

61. The mailing came in an envelope with no return address and consisted of three separate and distinct pages. (Exhibit 14) Each page was written by Respondent. (Respondent Testimony at 607-09) Its first page is dated September 15, 2013 and titled "Mercury Free Dentistry Week." Its second page is undated, untitled, and includes information on Lyme disease, dementia, mold, and mental illness. Its third page is dated September 2013 and titled "Cutting Edge Healthcare Findings" (Exhibit 14)

62. I find the mailing was advertising for the following reasons. First, staff member Calvano who was involved with the mailing considered it advertising. (Calvano Testimony at 1147) Second, that it was sent to people within a five to ten mile radius from the practice suggests a solicitation for new patients. Third, Respondent's claimed credentials and uniqueness are repeatedly referenced and often the focal point of it. (Exhibit 14) Fourth, both the Seekonk and Attleboro office telephone numbers are listed as well as a website. (Exhibit 14) Fifth, the mailing contains statements involving health concerns, references to importance of being checked, and Respondent's claimed experience or credentials in the applicable area. (Exhibit 14) Based upon the above demonstrating the mailing was advertising, I reject Respondent's contention the mailing was not advertising and was sent for "informational purposes." (Respondent Testimony at 1734-40)

63. At the bottom of the first and the second page of the mailing is Respondent's name with the following abbreviations: DMD, EJD, MS, MBA, CAGS, TCM,

UHSA School of Medicine, MAGD, MICCMO AND DAAPM. The first page also includes IAO. (Exhibit 14)

64. DMD stands for Doctor of Dental Medicine. MBA stands for Masters of Business Administration. MS stands for Masters of Science in biomechanical trauma. CAGS stands for Certificate of Advanced Graduate Study in health care management. DAAPM stands for Diplomat of the American Academy of Pain Management. EJD stands for Executive Juris Doctorate. (Exhibit 4)

65. TCM stands for Traditional Chinese Medicine Certificate from Chengdu University. (Exhibit 4) Respondent did not know whether TCM was a degree or a certificate. (Respondent Testimony at 612-13) I find it was not a degree because his curriculum vitae and the mailing reference it as a certificate. (Exhibits 4, 14)

66. UHSA School of Medicine stands for University Health Sciences Antigua School of Medicine. (Exhibit 4) Respondent did not graduate from the USHA program. (Respondent Testimony at 613-14)

67. IAO stands for International Association of Orthodontists. (Exhibit 4) IAO is an advanced training in orthodontics. Respondent is not board certified in orthodontics. (Respondent Testimony at 615-16)

68. MAGD stands for the Mastership in the Academy of General Dentistry. (Exhibit 14) That academy is a general dentistry academy where a dentist can become a member by paying an annual fee. Respondent took all the required courses offered by the academy to achieve fellowship and then mastership status. (Respondent Testimony at 616-17)

69. MICCMO stands for Mastership in the International College of Craniomandibular Orthopedics. (Exhibit 4) This is an organization for neural muscular dentistry. Respondent fulfilled the organization's requirements to attain fellowship and then mastership. (Respondent Testimony at 617-18)

70. The bottom of the second page of the mailing states "[Dr. Satloff] is Massachusetts' first academically trained cosmetic dentist (CWRU 1990 and Tufts 1995)." (Exhibit 14) Respondent completed a certificate in the post-graduate program in esthetic dentistry in 1991-92 at Case Western Reserve University School of Dentistry and completed certification for continuum in aesthetic dentistry in 1995 at Tufts University School of Dental Medicine. (Exhibit 4)

71. The bottom of the third page of the mailing states "Dr. Satloff is the first doctor in New England academically trained with a Masters degree in biomechanical trauma due to MVA issues. Dr. Satloff was in the first class of doctors in the United States in 1990 to be awarded Diplomat status in the American Academy of Pain Management. He was also the first doctor in New England to be awarded

both Mastership and Regent status in New England for TM joint issues and sleep concerns for the International College of Craniomandibular Orthopedics. In addition to doctoral training in law, dentistry and medicine (candidate), he possesses a Certificate in Traditional Chinese Medicine from Chengdu University." (Exhibit 14)

72. As a dentist licensed in Massachusetts, Respondent knew or should have known of his obligation under 234 CMR 5.20 to observe and comply with the Principles of Ethics and Code of Professional Conduct, January 2004 of the American Dental Association (ADA Code). (Stipulation 3; Exhibit 23) The ADA Code states "The Code of Professional Conduct is an expression of specific types of conduct that are either required or prohibited. The Code of Professional Conduct is a product of the ADA's legislative system." The ADA Code states its "Advisory Opinions are interpretations that apply the Code of Professional Conduct to specific fact situations. They are adopted by the ADA's Council on Ethics, Bylaws and Judicial Affairs to provide guidance to the membership on how the Council might interpret the Code of Professional Conduct in a disciplinary proceeding." (Exhibit 23)

73. ADA Code at Code of Professional Conduct 5.F. states "[a]lthough any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication that is false or misleading in any material respect." Advisory opinion 5.F.3. states "The use of a nonhealth degree in an announcement to the public may be a representation which is misleading because the public is likely to assume that any degree announced is related to the qualifications of the dentist as a practitioner."

74. The mailing was misleading in a material respect by its inclusions of any and all of the following designations: MS, MBA, CAGS and EJD.

a. None of these are health degrees and the public is likely to assume they are related to the qualifications of Satloff as a dentist practitioner.

b. EJD is not a health degree. (Respondent Testimony at 609-10, 904-05)

c. Further, in 2000, the Massachusetts Dental Society Ethics Committee advised Respondent to remove references to his master's degree in trauma, his master's degree in health care and the CAGS certificate from his advertising. (Respondent Testimony at 620-23; Exhibit 54) I infer such prohibition was because MS, MBA, and CAGS are not related to the qualifications of the dentist as a practitioner. (Exhibit 23 at 5.F.3)

The mailing violated ADA Code at Code of Professional Conduct 5.F and thus 234 CMR 5.20 with each of these inclusions.

75. The special areas of dental practice approved by the ADA are dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics. (Exhibit 23 at Code of Professional Conduct 5H)

76. ADA Code at Code of Professional Conduct 5.I. states "General dentists who wish to announce the services available in their practices are permitted to announce the availability of those services so long as they avoid any communications that express or imply specialization. General dentists shall also state that the services are being provided by general dentists. No dentist shall announce available services in any way that would be false or misleading in any material respect."

> Advisory opinion 5.I.1 prohibits a general dentist from announcing to the public he is certified or a diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless the dentist discloses he is a general dentist and the announcement includes "[Name of announced area of dental practice] is not recognized as a specialty area by the American Dental Association."
>
> Advisory opinion 5.I.2 allows general dentists to announce fellowships or other credentials earned in the area of general dentistry "so long as they avoid any communications that express or imply specialization and the announcement includes the disclaimer that the dentist is a general dentist. The use of abbreviations to designate credentials shall be avoided when such use would lead the reasonable person to believe that the designation represents an academic degree, when such is not the case." (Exhibit 23)

In each of the ways depicted in paragraphs 77-81 the mailing was false or misleading in a material respect, violating ADA Code at Code of Professional Conduct 5.I and 234 CMR 5.20.

77. The mailing stated "Dr. Satloff was in the first class of doctors in the United States in 1990 to be awarded Diplomat status in the American Academy of Pain Management." (Exhibit 14) Although pain management is not a specialty area of practice approved by the ADA, the mailing did not disclose Respondent is a general dentist or state pain management is not recognized as a specialty area by the ADA. (Exhibit 14) Further, a reasonable reader would conclude Respondent was expressly or implying a specialty in pain management.

78. The mailing stated "[Dr.. Satloff] was also the first doctor in New England to be awarded both Mastership and Regent status in New England for TM joint issues and sleep concerns from the International College of Craniomandibular Orthopedics." (Exhibit 14) Respondent testified he fulfilled the requirements to attain fellowship and mastership. (Respondent Testimony at 617-18) An

inference is drawn the Mastership and Regent positions constitute "diplomate or otherwise similarly credentialed" positions. Although neither TM joint issues nor sleep concerns are specialty areas of practice approved by the ADA, the mailing did not disclose Respondent is a general dentist or that TM joint issues and/or sleep concerns is not recognized as a specialty area by the ADA. (Exhibit 14) Further, a reasonable reader would conclude Respondent was expressly or implying a specialty in TM joint issues and/or sleep concerns.

79. The mailing stated "Dr. Satloff is the first doctor in New England academically trained with a Masters degree in biomechanical trauma due to MVA issues." (Exhibit 14 at 5) Although biomechanical trauma is not a specialty area of practice approved by the ADA, the mailing did not disclose Respondent is a general dentist or state that biomechanical trauma is not recognized as a specialty area by the ADA. (Exhibit 14) Further, a reasonable reader would conclude Respondent was expressly or implying a specialty in biomechanical trauma.

80. The mailing stated "[I [Dr. Satloff] was the first dentist in Massachusetts and Rhode Island trained in tooth colored restorations at Case Western Reserve University in 1990 to forego the use of mercury based restorations because of toxicity concerns." (Exhibit 14) The mailing stated "[Dr. Satloff] is Massachusetts' first academically trained cosmetic dentist (CWRU 1990 and Tufts 1995)." (Exhibit 14) Although cosmetic dentistry is not a specialty area of practice approved by the ADA, the mailing did not disclose Respondent is a general dentist or that cosmetic dentistry is not recognized as a specialty area by the ADA. (Exhibit 14) Further, a reasonable reader would conclude Respondent was expressly or implying a specialty in cosmetic dentistry.

81. The mailing included each of the following abbreviations: MAGD, MICCMO, DDAPM and IAO. (Exhibit 14) These letters refer to organization or board certification/designations. Such listings would lead a reasonable person to incorrectly believe each designation represents an academic degree.

82. ADA Code at Code of Professional Conduct 5.E. states "Dentists should not misrepresent their training and competence in any way that would be false or misleading in any material respect." Respondent violated this provision by listing UHSA School of Medicine on two pages of the mailing after his name. Respondent did not graduate from this program and the record is void of any evidence meriting an authorized association between Respondent and it. A reasonable person reviewing the mailing would conclude Respondent graduated from the UHSA School of Medicine and/or had an official relationship with it when neither is accurate. Although on the third page of the mailing Respondent writes, "In addition to doctoral training in law, dentistry and medicine (candidate), he possesses a Certificate in Traditional Chinese Medicine from Chengu University," this is insufficient notice to the reader that Respondent was only a candidate for some kind of medical degree from UHSA School of Medicine. By listing UHSA School of Medicine, Respondent misrepresented his training and

competence in a way that was false and/or misleading in a material respect in violation of ADA Code at Code of Professional Conduct 5.E and 234 CMR 5.20.

83. ADA Code at Code of Professional Conduct 5.F. states "Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication that is false or misleading in any material respect."

> ADA Code at Advisory opinion at 5.F.2. includes as an example of a statement that is false or misleading in a material respect one "intended or [] likely to create an unjustified expectation about results the dentist can achieve."
>
> ADA Code at Advisory opinion at 5.F.2. includes as another example of a statement that is false or misleading in a material respect one that "contain[s] material, objective representation, whether express of implied, that the advertised services are superior in quality to those of other dentists, if that representation is not subject to reasonable substantiation." (Exhibit 23)

84. Respondent wrote the following on the second page of the mailing.

> Such unclear thinking is the proximate result of unresolved infections affecting the cerebral cortex.... [He] suffered all of his life with this issue but no healthcare professional including psychological counselors ever intervened. This was a sad event for all involved but it was preventable with appropriate intervention.... Early intervention with appropriate testing and appropriate detoxification of infection is critical [regarding dementia]. Infection primarily gests into the brain via either the cranial joints or by infections of maxillary teeth or acute maxillary periodontal abscesses. All infections need to be properly addressed."

Respondent wrote the following on the third page of the mailing.

> Infectious Burden (IB) ... is the primary factor in a whole host of significant health issues like heart attacks [], strokes ... coronary artery disease [] and the like. Dr. Satloff has developed an index to measure IB which allows an individual to quickly identify one's risk for such an occurrence.... Second, [Dr. Satloff's] article introduces how proteomic biomarkers can be used for many dental issues. Proteomic biomarkers are proteins that can quantify the presence of different disease states like infection, cancer .... Third the [Dr. Satloff] paper explores the nature of unresolved infection both from teeth and from cranial joints.... [I]f the infection drains to the brain, this makes an individual susceptible for anxiety and depression issues, and is directly related to dementia burden in the elderly. Fourth, the [Dr. Satloff] article delves into the relationship between mandibular teeth infections and cancer of the lymph nodes,

thyroid, and of the breast.... It is so important to properly detox all tooth and cranial joint infections.

85. Each passage in paragraph 84 violates ADA Code at Code of Professional Conduct 5.F (and thus 234 CMR 5.20) in two ways. First, it expresses or implies Respondent has a medical degree and can diagnose or treat non-dental conditions and is likely to create an unjustified expectation about the results Respondent could achieve. Second, it is a statement of a character claiming professional superiority not subject to reasonable substantiation.

86. Each passage in paragraph 84 violates ADA Code at Code of Professional Conduct 5.A. which states "[d]entists shall not represent the care being rendered to their patients in a false or misleading manner." (Exhibit 23) Advisory opinion 5.A.2 provides "dentist who represents that dental treatment or diagnostic techniques recommended or performed by the dentist has the capacity to diagnose, cure or alleviate diseases, infections, or other conditions, when such representations are not based upon accepted scientific knowledge or research is acting unethically." Each passage represents a capacity to diagnose, cure or alleviate diseases, infections, or other conditions but without any basis of accepted scientific knowledge or research.

87. Each violation of the ADA Code (and 234 CMR 5.20) described in paragraphs 73-86 subjects Respondent's license to discipline by the Board on each of the following independent grounds:

a. 234 CMR 9.05(2) (violating duties and standards set out in 234 CMR);

b. undermines the public's confidence in the profession's integrity in violation of 234 CMR 9.05(1) and Sugarman principle;

c. pursuant to 234 CMR 9.05(1) for engaging in misconduct in the practice of dentistry by demonstrating a lack of concern for one's conduct (See Hellman, 404 Mass. at 804);

d. as intentional wrongdoing or lack of concern for one's conduct constituting misconduct in the practice of dentistry under 234 CMR 9.05(1) (See Hellman, 404 Mass. at 804);

e. failure to comply with established ethical standards of the profession pursuant to 234 CMR 9.05(17);

f. pursuant to 234 CMR 9.05(8) for placing at risk the public health, safety or welfare;

g. pursuant to 234 CMR 9.05(14) for violating recognized standards of care; and

h. pursuant to the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass. at 252)

88. Pursuant to G.L. 112, § 52A, a registered dentist is prohibited from including or causing to be included in an advertisement information not susceptible to reasonable verification by the public. The third paragraph of the second page of the advertisement contains technical assertions not susceptible to reasonable verification by the public. The offensive statements are:

a. "proteomic biomarker amyoid 1-42 measures neuropsychological functioning";

b. "titres of beta amyloid above 300 nanograms makes an individual susceptible for anxiety";

c. "titres above 600 nanograms makes an individual susceptible to depression"; and

d. "such unclear thinking is the proximate result of unresolved infection affecting the cerebral cortex."

By violating G.L. c. 112, § 52A, Respondent's license is subject to discipline by the Board pursuant to the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass. at 252)

C. INSPECTIONS

89. As a dental health-care personnel and licensed dentist who provides dental treatment, Respondent knew or should have known of his obligation under 234 CMR 5.05(1) to observe and comply with the standards of Recommended Infection Control in Dental Health-Care Settings-2003, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta (CDC Guidelines). (Stipulation 3) Respondent is required to comply with Board regulations and CDC Guidelines and updates. (Eklund Testimony at 509-37)

90. Kathy Eklund, MHP, RDH, is an expert in the CDC guidelines in dental health care settings. Eklund received her Certificate of Dental Hygiene Education in 1975 from Ohio State University (OSU); earned a Bachelor of Science in Education in 1975 from OSU; earned a Master of Public Health in 1997 from Boston University School of Public Health; has been a registered dental hygienist since 1975; worked from 1985 to the present for The Forsyth Institute (formerly Forsyth Dental Center), a biomedical research center, in various capacities and is currently Director of Occupational Health and Safety; and worked with The Forsyth Institute and CDC from 1998 until 2003 on the development on the CDC Infection Control Practices in Dentistry. (Eklund at 509-12; Exhibits 20, 22)

NORTH ATTLEBORO INSPECTION

91. On October 23, 2013, a compliance inspection was conducted by Board Investigators (Investigators) at the dental practice Respondent owns located at 44 Whiting Street, North Attleboro ("NA"), Massachusetts. (Stipulation 57; Exhibit 9)

The NA practice administered local anesthesia. (Exhibit 9 at 3; Seeley-Murphy Testimony at 431) Respondent was present during the inspection. The Investigators conducted the inspection based on an onsite inspection form. The Investigators took photographs, worked with a staff person designated by Respondent, wrote a report of the deficiencies onsite and reviewed the report with Respondent onsite. Respondent had the opportunity to dispute any deficiencies on the list. Respondent signed the report (NA Report). (Exhibit 9; Seeley-Murphy Testimony at 411-15, 442-45; Yates Testimony at 401-02)

92. CDC Guidelines provide "Monitor sterilizers at least weekly by using a biological indicator with a matching control (i.e., biological indicator and control from same lot number)." CDC Guidelines VI(F)(6). "Biological indicators [] (i.e., spore tests) are the most accepted method for monitoring the sterilization process because they assess it directly by killing known highly resistant microorganisms … rather than merely testing the physical and chemical conditions necessary for sterilization." (Exhibit 22, CDC Guidelines at p. 24)

93. At all material time, Respondent's office performed spore testing by mailing test strips to Biological Monitoring System (BMS) who determined whether any growth was observed after an incubation period. BMS maintained a record of the testing results, which were provided by Respondent's staff, to the Investigators. There were no BMS records of weekly spore tests results for the NA office for the weeks in 2013 of: September 1; July 7; June 23; May 26; May 6; April 21; and January 6. (Exhibit 9 at 147-49; Seeley-Murphy Testimony at 445-54) I find Respondent's NA office failed to conduct spore testing for each of such weeks, based on the following.

a. There are no BMS records of weekly spore tests results for the NA office for these weeks.

b. Respondent did not provide any sterilization monitoring records evidencing spore testing at the NA office was conducted on any of those weeks.

c. I reject Respondent's contention his NA office mailed spore test strips to BMS on those weeks and the missing test results occurred because the United States Post Office mutilated the spore test envelopes so the spore test strips were never received by BMS. Respondent testified two to three mutilated envelopes were sent to the Board. (Respondent Testimony at 1550-51) But, there was no showing mail processing issues repeatedly interfered with the submission of spore test material sent from the NA office to BMS. While there is one post office return of test strip material, it was several weeks after the Investigation and does not impact the weeks in question. (Exhibit 53)

94. Each failure to perform weekly spore testing at the NA practice subjects Respondent's license to discipline by the Board on the following independent grounds.

a. Respondent violated 234 CMR 5.05(1) which in turn violates 234 CMR 9.05(3) (comply with *CDC Guidelines*) and 234 CMR 9.05(2) (violating duties and standards set out in 234 CMR).

b. By demonstrating a lack of concern for one's conduct, Respondent engaged in misconduct in the practice of dentistry in violation of 234 CMR 9.05(1). (See Hellman, 404 Mass. at 804)

c. By engaging in conduct that undermines public confidence in the integrity of the dental profession, Respondent violated 234 CMR 9.05(1) and Sugarman principle.

d. By not adhering to CDC Guidelines, Respondent violated the malpractice prong of G.L. c. 112, § 61 because there is a relationship between accepted standards of practice and the malpractice in the practice of profession prong. (See Fitzgerald, 399 Mass. at 904-05)

e. By placing public health, safety or welfare at risk, Respondent violated 234 CMR 9.05(8).

f. By violating Board regulation(s), Respondent violated the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass at 252)

Further, failing to perform weekly spore testing on multiple weeks at the NA practice subjects Respondent's license to discipline by the Board pursuant to the gross misconduct in the practice of the profession prong within G.L. c. 112, § 61 by engaging in intentional, flagrant and extreme wrongdoing. (See Hellman, 404 Mass. at 804)

95. CDC Guidelines reflect the necessity of proper disinfecting of clinical contact surfaces; of proper sterilization including storage of equipment; and of a written infection control protocol on which staff are properly trained. (Exhibit 22)

96. The NA Inspection demonstrates the following violations of CDC Guidelines:

a. Clinical contact surfaces should be disinfected with an EPA-registered hospital disinfectant after each patient. Disinfectants should be used according to the manufacturer's instructions. (Exhibit 22 at 44) Cavicide is an EPA-registered hospital disinfectant. The NA practice had an opened expired Cavicide spray disinfectant (Seeley-Murphy Testimony at 421-23; Exhibit 9 at 1 and 105) which I infer was used to disinfect clinical contact surfaces. Use of expired Cavicide is not in accordance with

manufacturer's instructions (Eklund Testimony at 517-20) and violates the CDC Guidelines.[10]

b. Chemical indicators should be placed on the inside of each package. If the internal indicator is not visible from the outside, an exterior chemical indicator should be placed on the package. (Exhibit 22 at 43) The NA Inspection revealed Respondent failing to utilize internal chemical indicators in sterilization pouches, as evidenced by the Investigators' observation of: sterilized instruments in sterilization pouches with external indicators only; unused sterilization pouches with external indicators only; and absence of any internal indicator strips. (Stipulation 60)

c. Respondent failed to maintain the sterility of burs and diamonds, as evidenced by the Investigators' observation of burs and diamonds being stored outside of sterilization pouches prior to use. (Stipulation 61)

d. Pursuant to CDC Guidelines, a written Infection Control Program should be established with annual employee training. (Exhibit 22 at 39; Eklund Testimony at 516-17) The NA practice did not have a written Infection Control Program and did not have annual employee training. (Exhibit 9 at pages 1, 11 and 11B; Seeley-Murphy Testimony at 419-20)

97. Each failure in paragraph 96 subjects Respondent's license to discipline by the Board on the following independent grounds.

a. Respondent violated 234 CMR 5.05(1) which in turn violates 234 CMR 9.05(3) and 234 CMR 9.05(2).

b. By demonstrating a lack of concern for conduct, Respondent engaged in misconduct in the practice of dentistry in violation of 234 CMR 9.05(1). (See Hellman, 404 Mass. at 804)

c. By engaging in conduct that undermines public confidence in the integrity of the dental profession, Respondent violated 234 CMR 9.05(1) and Sugarman principle.

d. By not adhering to CDC Guidelines, Respondent violated the malpractice in the practice of the profession prong of G.L. c. 112, § 61. (See Fitzgerald, 399 Mass. at 904-05)

e. By placing public health, safety or welfare at risk, Respondent violated 234 CMR 9.05(8).

[10] Allegations of violating CDC Guidelines concerning an unopened expired bottle of Cavicide were not proven.

f. By violating one or more Board regulations, Respondent violated the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass at 252)

Further, collectively the failures in paragraph 96 subject Respondent to discipline by the Board pursuant to the gross misconduct in the practice of the profession prong of G.L. c. 112, § 61 by engaging in intentional, flagrant and extreme wrongdoing. (See Hellman, 404 Mass. at 804)

98. "The role of the [B]oard in the over-all statutory scheme is to take primary responsibility in the regulation of the practice of dentistry in order to promote the public health, welfare, and safety." Anusavice v. Board of Registration in Dentistry, 451 Mass. 786, 793-94 (2008). The Board promulgated regulations including the following: 234 CMR 5.16(1) which requires a written protocol for managing medical and dental emergencies; 234 CMR 5.16(4) which requires staff are annually trained to implement emergency protocol; 234 CMR 5.16(2) which requires a dental practice to maintain a current emergency drug kit; 234 CMR 6.15(2) which requires a dental practice to have certain equipment and supplies for the administration of local anesthesia; and 234 CMR 6.15(3) which requires a dental practice to have certain drugs and/or categories of drugs required for administration of local anesthesia.

99. Respondent violated 234 CMR 5.16(1). The NA practice did not have a written protocol for managing medical and dental emergencies. (Exhibit 9 at pages 1, 6, 11A; Seeley-Murphy Testimony at 418-20 and 438-39)

100. Respondent violated 234 CMR 5.16(4). The NA practice did not have annual employee training of written emergency protocol. (Exhibit 9 at pages 1, 6 and 11A; Seeley-Murphy Testimony at 418-20 and 438-39)

101. Respondent violated 234 CMR 5.16(2). The NA practice failed to possess a current emergency drug kit, as evidenced by the presence of the following expired drugs: Epinephrine pre-loaded syringe (adult), expired in 9/2013; One (1) Antihypoglycemic, expired in 10/2011; One (1) Antihypoglycemic, expired in 7/2013; Bronchodilator, expired in 6/2013; Midazolam, expired in 1/2012; Vasodilator, expired in 4/2008; and Tigan, Expired in 5/2012. (Stipulation 65; Exhibit 9 at 4)

102. Respondent's NA dental practice violated the following provisions within 234 CMR 6.15(2) because although it administered local anesthesia (Exhibit 9 at 3) it did not have the following equipment and supplies:

a. 234 CMR 6.15(2)(b): Automated External Defibrillator (AED); pediatric AED (Stipulation 67; Exhibit 9 at 4); and expired adult pads (Exhibit 9 at 4 and Seeley-Murphy Testimony at 436);

b. 234 CMR 6.15(2)(c): disposable CPR masks (pediatric); (Stip. 67);

e. 234 CMR6.15(2)(e): disposable pediatric face masks or positive pressure ventilation with supplemental oxygen; (Stipulation 67);

d. 234 CMR 6.15(2)(f): oxygen (portable Cylinder E tank) pediatric and adult masks capable of giving positive pressure ventilation (including bag-valve-mask system); (Stipulation 67); and

e. 234 CMR 6.15(2)(g): sphygmomanometer and stethoscope; (Exhibit 9 at 4; Seeley-Murphy Testimony at 437)

103. Respondent's NA practice failed to have the following required drugs and/or categories of drugs required for administration of local anesthesia: current and non-expired Bronchodilator for emergency use (Stipulation 65; Exhibit 9 at 4) in violation of 234 CMR 6.15(3)(e); and current and non-expired Epinephrine preloaded syringes (pediatric) for emergency use (Stipulation 69) in violation of 234 CMR 6.15(3)(f).

104. Each failure in paragraphs 99-103 subjects Respondent's license to discipline by the Board on the following independent grounds.

a. By demonstrating a lack of concern for conduct, Respondent engaged in misconduct in the practice of dentistry in violation of 234 CMR 9.05(1). (See Hellman, 404 Mass. at 804)

b. By engaging in conduct that undermines public confidence in the integrity of the dental profession, Respondent violated 234 CMR 9.05(1) and Sugarman principle.

c. By placing public health, safety or welfare at risk, Respondent violated 234 CMR 9.05(8).

d. Respondent violated 234 CMR 9.05(2) (violating duties and standards set out in 234 CMR).

e. By violating one or more Board regulations, Respondent violated the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass at 252)

Further, collectively the failures in paragraphs 99-103 subject Respondent's license to discipline by the Board pursuant to the gross misconduct in the practice of the profession prong within G.L. c. 112, § 61 by engaging in intentional, flagrant and extreme wrongdoing. (See Hellman, 404 Mass. at 804)

105. Respondent violated 234 CMR 5.04(3) which requires all licensees and dental auxiliaries providing dental services to a patient, or assisting a dentist in the

direct care or treatment of a patient, wear a name tag with the individual's name and professional title and function. Neither Respondent nor his staff wore name tags at the time of the NA inspection. (Exhibits 9 at 1, 8, 11; Seeley-Murphy Testimony at 418-20, 439, 441) Although Respondent testified he had his name embroidered on lab coats, he had no recollection of providing them to Investigators. (Respondent Testimony at 1717-18) An Investigator testified she observed Respondent wearing a lab coat but it did not have his name embroidered on it. (Seeley-Murphy Testimony at 420) This violation of a Board regulation subjects Respondent's license to discipline by the Board pursuant to the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 at 252)

106. Respondent violated 234 CMR 5.04(1). Respondent failed to post his license at his practice where it could be observed by the public. (Exhibit 9 at 1 and 8; Seeley-Murphy Testimony at 417-18, 439). This violation of a Board regulation subjects Respondent's license to discipline by the Board pursuant to the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 at 252)

107. Pursuant to CDC Guidelines, FDA-cleared sterilants should be used in cold sterile immersion containers; (Exhibit 22 at 42) Cavicide was in the cold sterile immersion container. (Exhibit 9 at 2; Seeley-Murphy Testimony at 420-22) It was not determined at the hearing that Cavicide is not an FDA-cleared sterilant. It was not proven Respondent violated CDC Guidelines with respect to this matter.

SEEKONK INSPECTION

108. On October 29, 2013, a compliance inspection was conducted by Investigators at the dental practice Respondent owned located at 153 Fall River Avenue, Seekonk, Massachusetts 02771 (Seekonk Inspection). (Stipulation 73; Exhibit 10) The Seekonk practice administered local anesthesia. (Exhibit 10 at 3; Seeley-Murphy Testimony at 431) The Investigators conducted the inspection based on an onsite inspection form. Respondent was present during the inspection. The Investigators took photographs, worked with a staff person designated by Respondent, wrote a report of the deficiencies and reviewed the report with Respondent onsite. Respondent had the opportunity to dispute any deficiencies on the list. Respondent signed the report (Seekonk Report). (Exhibit 10; Seeley-Murphy Testimony at 457-59, 466; Yates Testimony at 402-03)[11]

109. The Seekonk Inspection demonstrates the following violations of CDC

[11] During the later portion of the direct examination of Seeley-Murphy some of the questions asked by Prosecuting Counsel inadvertently refer to the "North Attleboro Inspection" instead of the "Seekonk Inspection." This has no impact on the reliability of Seeley-Murphy's testimony as it is clear from the record the examination moved from the North Attleboro Inspection to the Seekonk Inspection and the documents referred to by Seeley-Murphy during this part of the testimony refer to and are consistent with Seekonk Inspection Report. (See Seeley-Murphy Testimony at 457-59; Exhibit 10)

Guidelines.

a. The Seekonk practice had an opened Cavicide spray disinfectant with an expiration date of 3/2011. (Exhibit 10 at 2, 10A, 95; Seeley-Murphy Testimony at 459-60) I infer it was used to disinfect clinical contact surfaces.

b. At the Seekonk practice burs and endo files were in sterilized pouches without chemical indicators. (Exhibit 10 pages 2 and 10; Seeley-Murphy Testimony at 462-63)

c. Usable patient care items should be sterilized in accordance with a process that has received Food and Drug Administration clearance and then wrapped and placed in containers designed to maintain sterility during storage. (Exhibit 22 at 43; Eklund Testimony at 517-25) The Seekonk practice failed to have burs and diamonds in bur blocks stored in operatory drawers prior to use. (Stipulation 75; Seeley-Murphy Testimony at 460-62) Further, at the Seekonk practice some hand-pieces that were not in use were not bagged. (Exhibit 10 at 2, 99; Seeley-Murphy Testimony at 460-62)

110. Each failure in paragraph 109 at the Seekonk practice subjects Respondent's license to discipline by the Board on the following independent grounds.

a. The conduct did not comply with the CDC Guidelines which violated 234 CMR 5.05(1) which in turn violates 234 CMR 9.05(3) and 234 CMR 9.05(2) (violating duties and standards set out in 234 CMR).

b. By demonstrating a lack of concern for conduct, Respondent engaged in misconduct in the practice of dentistry in violation of 234 CMR 9.05(1). (See Hellman, 404 Mass. at 804)

c. By engaging in conduct that undermines public confidence in the integrity of the dental profession, Respondent violated 234 CMR 9.05(1) and Sugarman principle.

d. By not adhering to CDC Guidelines, Respondent violated the malpractice in the practice of the profession prong of G.L. c. 112, § 61. (See Fitzgerald, 399 at 904-05)

e. By placing public health, safety or welfare at risk, Respondent violated 234 CMR 9.05(8).

f. By violating one or more Board regulations, Respondent violated the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass at 252)

Further, collectively the failures in paragraph 109 subject Respondent's license to discipline by the Board pursuant to the gross misconduct in the practice of the profession prong within G.L. c. 112, § 61 by engaging in intentional, flagrant and extreme wrongdoing. (See Hellman, 404 Mass. at 804)

111. Respondent violated the following provisions within 234 CMR 6.15(2) by failing to have the following required equipment and supplies for administration of local anesthesia:

a. 234 CMR 6.15(2)(b): AED, pediatric automated external defibrillator pads (Stipulation 81) and expired adult pads (Stipulation 83);

b. 234 CMR 6.15(2)(d): disposable syringes, assorted sizes; (Exhibit 10 at 6; Seeley-Murphy Testimony at 464);

c. 234 CMR6.15(2)(e): disposable pediatric face masks or positive pressure ventilation with supplemental oxygen (Stipulation 81); and

d. 234 CMR 6.15(2)(g): stethoscope. (Exhibit 10 at 4; Seeley-Murphy Testimony at 464)

112. Respondent failed to have the following required drugs and/or categories of drugs required for administration of local anesthesia in violation of the following provisions within 234 CMR 6.15(3):

a. 234 CMR 6.15(3)(c): current and non-expired Antihistamine for emergency use (Exhibit 10 at 4);

b. 234 CMR 6.15(3)(e): current and non-expired Bronchodilator for emergency use (Stipulation 82);

c. 234 CMR 6.15(3)(f): current and non-expired Epinephrine preloaded syringes (adult) for emergency use (Exhibit 10 at 4); and

d. 234 CMR 6.15(3)(g): current and non-expired two epinephrine ampules, for emergency use. (Exhibit 10 at 4)

113. Respondent testified the dentist from whom he purchased the Seekonk practice in 2008 took items in 2008 unbeknownst to Respondent related to the deficiencies found in the Seekonk Report. (Respondent Testimony at 1613-28) Respondent's allegations were not proven. In any event, any removal of items in 2008 would not alleviate Respondent from operating his dental practice in compliance with CDC Guidelines and Board regulations in 2013.

114. Each failure in paragraphs 111-112 at the Seekonk practice subjects Respondent's license to discipline by the Board on the following independent grounds.

a. By demonstrating a lack of concern for conduct, Respondent engaged in misconduct in the practice of dentistry in violation of 234 CMR 9.05(1). (See Hellman, 404 Mass. at 804)

b. By engaging in conduct that undermines public confidence in the integrity of the dental profession, Respondent violated 234 CMR 9.05(1) and Sugarman principle.

c. By placing public health, safety or welfare at risk, Respondent violated 234 CMR 9.05(8).

d. Respondent violated 234 CMR 9.05(2) (violating duties and standards set out in 234 CMR).

e. By violating one or more Board regulations, Respondent violated the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass at 252)

Further, collectively the failures in paragraphs 111-112 subject Respondent's license to discipline by the Board pursuant to the gross misconduct in the practice prong within G.L. c. 112, § 61 by engaging in intentional, flagrant and extreme wrongdoing. (See Hellman, 404 Mass. at 804)

115. Neither Respondent nor his staff wore name tags at the time of the Seekonk inspection (Exhibit 10 at 8 and 11; Seeley-Murphy Testimony at 458-59) in violation of 234 CMR 5.04(3) By violating 234 CMR 5.04(3), Respondent's license is subject to discipline by the Board pursuant to the offense against laws prong of G.L. c. 112, § 61. (See Giroux, 322 Mass. at 252)

116. It was not proven the Seekonk practice failed to have a written protocol for medical and dental emergencies. Although an Inspector testified she did not find a written protocol for medical and dental emergencies and references a certain page on the Seekonk Report which has a check mark in the "No" column for "Emergency Protocol Posted" (Exhibit 10 page 6; Seeley-Murphy Testimony at 464-65), on that same page there is a "Yes" checked off for "Documentation of Emergency Drills and Training." (Exhibit 10 page 6) Because there is uncertainty as to the meaning of these notations, I find Prosecution has not satisfied its burden.

117. It was not proven there was a lack of annual training of medical and dental emergencies at the Seekonk office. The Seekonk Report has a checkmark in the "yes" column for "Documentation of yearly office training" (Exhibit 10 at 1) and a

"Yes" checked off for "Documentation of Emergency Drills and Training." (Exhibit 10 at 6)

118. It was not proven the Seekonk practice failed to have a written Infection Control Protocol. The Seekonk Report has a checkmark in the "Yes" column for "Office Manual/Documents Observed – Infection control protocol." (Exhibit 10 at 1)

119. It was not proven Respondent failed to maintain a current certification in Basic Life Support at the time of the inspections. Respondent did not provide his BLS certificate during the inspections. (Seeley-Murphy Testimony at 440-41 and 465; Exhibit 10 at 8) But in a letter dated December 9, 2013, Respondent's BLS certification was sent to the Board; the document indicates Respondent was BLS certified on July 18, 2013 with a recommended renewal date of July 31, 2015. (Exhibit 7)

D. PATIENT C

120. On or about February 13, 2013, Respondent treated Patient C. (Stipulation 87)

121. The Amended Order to Show Cause alleges regarding Respondent's treatment of Patient C: he failed to wear a mask or protective clothing; he failed to have Patient C execute a general informed consent; and he provided Patient C documentation that violated the ADA Code. None of these allegations were proven. I based this on the following. Patient C did not testify. It was Respondent's office practice to have patients sign a general informed consent form, and Respondent did not recall a situation of a patient not signing the form. (Respondent Testimony at 1556-57) The alleged documentation was not submitted in evidence. Respondent does not know what documents are being referred to. He may have handed forms to his patients but is not certain of any specific form. (Respondent Testimony at 1557-58) In making this finding I do not rely on Respondent's testimony he wore a protective mask and clothing when treating Patient C because while he recalls the "general incident," he does not remember Patient C. (Respondent Testimony at 930 and 1554-56)

E. OTHER[12]

122. Respondent's interest in "energy testing" was rooted in a few places.

Respondent graduated in 1981 from Tufts University School of Dental Medicine ("Tufts"). (Exhibit 4) After graduating, he volunteered in the

[12] I do not rely on the information within paragraphs 122-127 in making any findings of fact or determinations of law.

Alpha Omega Peace Corps in Golan Heights treating immigrant children with TMJ and headaches. There, he worked with a European-trained dentist who used "functional appliance therapies" Respondent had not learned in dental school. Respondent desired to learn more about how dentistry connected with other disciplines with the goal of helping patients. In 1988, Respondent did a one year residency with Dr. Noshir Mehta at the then-called Tufts Harold Gelb Pain Center. During that program, a two-person applied kinesiology testing technique was used directly on the patient to assess the patient's muscle strength. Respondent's participation in the residency further spawned his interest in related energy testing techniques. (Respondent Testimony at 945-947, 950-51, 953-58, 963-64) At some point around the 1990's Dr. Harold Gelb may have taught how to use applied kinesiology on a radiograph. But, that pain center does not currently teach students how to use applied kinesiology on a radiograph. (Dr. Metha Testimony at 789-90)

Respondent's interest in energy testing continued and he attended numerous workshops and seminars. Between 1998 and 2003, he attended virtually every seminar offered by the International College of Acupuncture and Electro-Therapeutics. During these seminars, Respondent heard from Dr. Omura energy testing can detect important invisible medical information which standard common laboratory tests often fail to detect. (Respondent Testimony at 1479-81; Exhibit 52)

123. Respondent believes[15] energy testing can be used in various ways:

a. Energy testing on an image can determine whether a person is susceptible to having a heart attack. The published "Satloff Index" measures the L-homocysteine titer of pathogens present in a person's heart. A measurement of 7.5 milligrams L-homocysteine is susceptible to a person having a heart attack. Television host of "The Biggest Loser" Bob Harper recently had a heart attack. Use of BDORT on a stock photo of Harper measured his L-homocysteine level at 7.5 milligrams. Use of BDORT on a hospital bed photo of Harper after he woke up from his trauma-induced coma after his heart attack measured his L-homocysteine level at 10.5 milligrams. (Respondent Testimony at 1066-68; Exhibit 7 at 1)

b. Energy testing on an image can reveal mental illness. Adam Lanza shot and killed several children in Newtown, Connecticut. Using an image of Lanza from a newspaper, Respondent used energy testing to determine Lanza's level of the proteomic biomarker, beta amyloid 1-42 which measures neuropsychological functioning. Lanza measured "off the scale" at 1,100 nanograms which makes an individual unable to think clearly.

[15] I merely credit Respondent holds these beliefs.

"Titres of beta amyloid above 300 nanograms makes an individual susceptible for anxiety and titres about 600 nanograms makes an individual susceptible to depression… Such unclear thinking is the proximate result of unresolved infection affecting the cerebral cortex." (Respondent Testimony at 895-99; Exhibit 14 at 4)

c. Energy testing on handwriting can determine if a patient tests positive for HPV-16. HPV slides were not available until 2015, however, you "could retrospectively assess the presence of HPV in Patient A by assessing her handwriting." Respondent used energy testing on the handwritten complaint Patient A forwarded to the Board to conclude Patient A [redacted] "I think I shared with you that the patient's [Patient A] handwriting resonates specifically with [redacted] in her writing to the Board in 2013."[14] "Again, what Dr. Omura teaches is that with bidigital O-ring testing, handwriting represents energy representation of the individual. It doesn't matter what they write. The handwriting is at a specific frequency, so off of that handwriting I could assess whether her frequency resonated with any of our slides." (Respondent Testimony at 598-601, 1481, 1574-75 and 1773-77)

d. He can use a one-handed, one-person energy testing technique to determine the presence of biomarkers on another individual. This technique is done without touching the patient, and does not involve an image or handwriting. At the hearing, while Patient A was testifying and unbeknownst to her or others in the room, Respondent was performing energy testing from his seat approximately 10 feet away. Respondent had a slide in one hand and was performing BDORT testing on Patient A for [redacted] "So in my hand I would be holding the slide, whether it was the [redacted] and I would be projecting my energy to the patient until I got resonance." (Respondent Testimony at 919-28)

124. Roxanne Lewicki has worked as a dental assistant/receptionist for Respondent for 27 years. Respondent trained her to assist him in performing energy testing which he uses on a daily basis. Lewicki believes in energy testing; believes Respondent believes in energy testing; and believes a lot of patients with unresolved issues find resolutions through his use of energy testing. (Lewicki Testimony at 1266-82)

125. Calvano worked as Respondent's dental assistant from approximately 2008-2014. I infer Respondent used energy testing on Calvano, determined two of her teeth were infected and put her on regimen of antibiotics that cleared up the infection. Calvano praises Respondent stating "I've worked for five, six, seven

[14] Patient A's complaint was received by the Board in May 2012. (Exhibit 11)

dentists before and I have never seen anyone so passionate about what they're doing or trying to help people in general. I mean he really did truly care about helping people and finding out what was the cause of things." (Calvano Testimony at 1123-36)

126. Patient E began seeing Respondent in August 2015 and is a current patient. Patient E knew Respondent performed energy testing. Energy testing was within Patient E's "wheelhouse" as she used such techniques in her position as an occupational therapist. Patient E believes Respondent used applied kinesiology to determine she had an unhealthy tooth. "He said that he felt that energetically, it was unhealthy." Respondent referred Patient E to an orthodontist who determined the tooth Respondent identified as unhealthy was cracked and performed a root canal. Patient E was very pleased with Respondent as she believed he "saved me from instant pain." Patient E further describes Respondent's use of energy testing on her as follows. Using energy testing, he determined Patient E [redacted] and prescribed fish oil. After taking the fish oil, the sensitivity in her tooth went down considerably and Respondent indicated the applied kinesiology was no longer picking up [redacted] He informed Patient E residual neurotoxins might be the cause for overall tooth sensitivity and she should take Chlorella. After taking the Chlorella for about eight days, the tooth sensitivity went away. Patient E was very pleased with Respondent; she found him to be a concerned dentist and professional. (Patient E Testimony at 969-971, 974-78, 982-983, 986-992, 997)

127. Patient D began seeing Respondent in 2005. She was dealing with several debilitating medical issues as a result of a [redacted] At the first appointment, Respondent did energy testing on Patient D; although she was not familiar with it, Respondent explained the process to her and how it worked. Patient D believes Respondent diagnosed bacteria in Patient D's system that others had not been able to detect. Respondent prescribed antibiotics. Patient D began to notice a difference in her condition within a couple months of seeing Respondent. "I can honestly say that Dr. Satloff has changed my quality of life for the better.... I'll never feel normal again but I'm the best that I can be.... I know I wouldn't feel this way be going to occupational therapy or being drugged through life to manage symptoms and stuff getting better." (Patient D Testimony at 478-484, 487-503)

III. PARTIES POSITIONS ON DISPOSITION[15]

RESPONDENT'S POSITION

Respondent maintains energy testing does not fall below the standards of care for dentists in Massachusetts. Respondent sufficiently documented his records as to treatment of Patient A and maintained adequate patient records. Any violations determined by the Board's inspectors were de minimus and based largely on conduct by Respondent's predecessor and not malpractice or gross misconduct. Respondent notified the Board and subsequently the inspector as to missing dental equipment he believed was due to his predecessor's conduct.

No patient, including Patient A, has been injured in any way by any conduct or misconduct. The Prosecution has failed to meet its burden with respect to the allegations concerning Patients B and C.

Any disproportionate disciplinary action by the Board would, ironically, chill the public's right, need and ability to seek treatment and care from the Respondent where their medical circumstances so required. Patients D and E were merely two examples of the many patients who have been fortunate for the care they received from Dr. Satloff, who has always been upfront about his strong belief in the efficacy of BDORT and energy testing in general under certain circumstances.

Any discipline must be consistent with precedent. Probation is a consistent discipline where major inspection violations have been determined. Record-keeping and billing violations, where proven, consistently carry a discipline of censure or probation where more severe. Violations of the standards of care, where proven, have also carried a discipline of probation.

Respondent's prior case was dismissed with prejudice following a hearing. The Board raised similar issues in that case that were raised in this case.

PROSECUTION'S POSITION

While the complaint stems from Respondent's treatment of Patient A, it is clear from the testimony of Patients D and E, as well as testimony of Respondent's assistants that he regularly conducts himself in the manner that he treated Patient A. Respondent gives this Board no assurances that he would modify his practice and bring it with the standards of care expected of a general dentist. Prosecution recommends the Board revoke Respondent's license to practice dentistry in the Commonwealth of Massachusetts.

[15] Each side relies upon case(s) in support of its respective position. This document does not address cases solely identified in the respective disposition memoranda.

IV. CONCLUSION

The Board has the authority to discipline Dr. Satloff's license and right to renew such license. The Board may impose an appropriate sanction.

V. LIST OF EXHIBITS

1. Stipulations with footnote (5 pages)

2. Amended Order to Show Cause (18 pages)

3. Amended Answer to Order to Show Cause (4 pages)

4. David Satloff Curriculum Vitae (3 pages)

5. David Satloff affidavit dated December 18, 2013 (1 page)

6. July 12, 2012 letter to Division of Health Professions Licensure (DHPL) Compliance Officer Barbara Yates (Yates) from David Satloff on Smith Duggan letterhead without attachments (9 pages)

7. December 9, 2013 letter to Yates from David Satloff on Smith Duggan letterhead with attachment of Exhibit C referenced therein (Exhibits A and B omitted) (3 pages)

8. May 13, 2014 letter to Yates from Dr. Paul Farsai (Farsai) with attached article, "*How Do You Surmise The Appropriateness of Commercial or Scientific Information?*" and Farsai Curriculum Vitae (27 pages)

9. DHPL BORD On-Site Inspection of Dr. David Satloff's North Attleboro office dated October 23, 2013 (15 pages) with photographs (131 pages) and Biological Monitoring Service test results (3 pages) (149 pages total)

10. DHPL BORD On-Site Inspection of Dr. David Satloff's Seekonk office dated October 29, 2013 (15 pages); with photographs (141) (156 pages total)

11. Patient A's Complaint to DHPL Office of Public Protection (OPP) dated May 19, 2012 with an OPP "Received" May 24, 2012 date stamp (14 pages)

12. Patient A's Records generated by Dr. David Satloff (18 pages)

13. Original Radiograph; (Note: The parties agree that the original radiograph will remain in the possession of Prosecuting Counsel in a secured location until further notice.)

14. Patient B Mailing with cover letter from Patient A (With Imposed Page Numbering) (5 pages)

15. Dr. Michelle Bento Lavall and Dr. John Balamas Records for Patient A (7 pages)

16. Report of the American Dental Association (ADA) Recognized Dental Specialty Certifying Boards dated April 2015 (16 pages)

17. ADA Policy Statement on Unconventional Dentistry (copyright 2017) (1 page)

18. Dr. George Just Curriculum Vitae (3 pages)

19. **(Withdrawn by Parties)**

20. Kathy Eklund Curriculum Vitae (29 pages)

21. **(Withdrawn by Parties)**

22. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Morbidity and Mortality Weekly Report, Recommendations and Reports, December 19, 2003, *Guidelines for Infection Control in Dental Health-Care Settings -2003*. (76 pages)

23. ADA *Principles of Ethics and Code of Professional Conduct*, with official advisory opinions revised to August 2011of the American Dental Association (Code of Conduct) (23 pages)

24. *Electric Pulp Testing: A Review*; authored by J. Lin and another in International Endodontic Journal, 2008; pp. 1-10. 10 (10 pages)

25. *Diagnosis in Molar Endodontics*; authored by D. Witherspoon and J. Regan; published in The Guidebook to Molar Endodontics, 2017, pp. 27-73 (46 pages)

26. *Energy Medicine in the US: Historical Roots and the Current Status*; undated online article by Dr. Karl Maret, pp. 1-19 (19 pages)

27. *Diagnosis of the Condition of the Dental Pulp: A Systematic Review* by A. Mejare, et. al. in 2012, published in International Endodontic Journal; p. 597-613 (16 pages)

28. *Technique Summary: Applied Kinesiology;* authored by A.Rosner, et.al in Chiro Access on February 11, 2011; pp. 1-4 (4 pages)

29. Copy of Affidavit of Dr. Yasuhiro Shimotsuura signed August 8, 1987 in support of Dr. Y. Omura's United States Patent and Trademark Office application filed October 8, 1985 for "BI-DIGITAL O-RING TEST FOR IMAGING AND DIAGNOSING INTERNAL ORGANS OF A PATIENT" filed online on Tomsgoodfiles.com(7 pages)

30. *On the Reliability and Validity of Manual Muscle Testing: A Literature Review*; authored by S. Cuthbert and G. Goodheart in Chiropractic & Osteopathy; 2007 (18 pages)

31. Copy of Affidavit of Dr. Joel Friedman signed August 8, 1987 in support of Dr. Y. Omura's United States Patent and Trademark Office application filed October 8, 1985 for "BI-DIGITAL O-RING TEST FOR IMAGING AND DIAGNOSING INTERNAL ORGANS OF A PATIENT" filed online on Tomsgoodfiles.com (3 pages)

32. *Methods of Diagnosis and Treatment in Endodontics: A Systemic Review* by Gunnar Bergenholtz and others; published in 2010 in the Swedish Council on Health Technology Assessment (27 pages, with missing page 15 placeholder)

33. *Comparative Studies of Muscles Involved in Bi-Digital O-Ring Test (BDORT)* (Abstract) by D. Lu; (undated) (no publishing information referenced) (6 pages)

34. *Using BDORT to Select the Compatible Sedatives to Minimize Morbidity and Mortality* (Abstract) by D. Lu and another; (undated) (no publishing information referenced) (2 pages)

35. Two article abstracts on Bi-Digital O-Ring Testing by Y. Omura (1994 and 1992) published in Acupunct Electrother Res. (pp. 1-2 of 3 and 1-2) (4 pages)

36. *Kinesiology/Muscle Testing*; published online at Energetic Healthcare and Dentistry, a website of Dr. Wolfe (undated) (3 pages)

37. Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice; April 2002; published by Federation of State Medical Boards; pp. 1-7. (7 pages)

38. *More than 97% of Human Papilloma virus Type 16 (HPV-16) was Found with Chrysotile Asbestos & Relatively Smooth Round Tumor Outline, and Less than 3% was found with HPV-18 and Tremolite Asbestos & Irregular Sawtooth-like Zigzag Outline in Breast Cancer Tissues in Over 500 Mammograms of Female Patients: Their Implications in Diagnosis, Treatment, and Prevention of Breast Cancer*; Y. Omura, MD, author and others, Acupuncture & Electro-Therapeutics Res, Int. J., 2013, pp. 211-224. (14 pages)

39. *Biological Markers for Pulpal Inflammation: A Systematic Review* by D. Rechenberg and others, published in 2016 in PLoS One (17 pages)

40. April 14, 2014 press release by Dr. David Satloff (2 pages)

41. Picture (redacted) of license in Respondent's office in December 2013 (redacted) (1 page)

42. Two (2) article abstracts articles (dated 1986) by Y. Omura on Bi-Digital O-Ring Testing, both published in 1986 in Acupunct Electrother Res; (3 pages)

43. *Pain Levels and Typical Symptoms of Acute Endodontic Infections; A Prospective, Observational Study* by D. Rechenberg and others published in BMC Oral Health, 2016 (10 pages)

44. Letter to editor authored by Dr. David Satloff to Journal of the American Dental Association as to oral cancer testing; September 2003 captioned "Oral Cancer Test" (2 pages).

45. Dr. David Satloff article (undated) (no publishing information referenced) (1 page)

46. Letter to Editor authored by Dr. David Satloff to Journal of the American Dental Association in August 2002 captioned "Dental Implant Success" (2 pages).

47. *Dental Kinesiology* by G. Eversaul, published in Basal Facts, Volume 7, Number 2 (undated), pp. 127-131 (5 pages)

48. *Indications of Antibiotic Propylaxis in Dental Practice-Review*; by C. Ramu and other, published in 2012 in Asian Pacific Journal of Tropical Biomedicine; (9 pages)

49. *Dental Pulp: Correspondences and Conuradictions Between Clinical and Histological Diagnosis*; by C. Giuroiu and others in 2015 published in BioMed Research International (8 pages)

50. *Evidence-Based Dentistry—What is It?* By M. Goldie, published on June 6, 2014 in DentistryiQ.com; (6 pages)

51. *Consequences of and Strategies to Deal with Residual Post-Treatment Root Canal Infection*; by M. Wu and others, published in International Endodontic Journal, 2006; pp. 343-356. (14 pages)

52. Seminars and workshops from the International College of Acupuncture and Electro-therapeutics; 2014-2016 (5 pages)

53. March 6, 2014 letter from Robert Landeau to DPH Compliance Officer Lisa Seeley-Murphy with United States Postal Service notification of damage and partial Protectop Test Strip(s) document (Exhibit 53) (3 pages)

54. August 3, 2005 Board of Registration in Dentistry, In the Matter of David Satloff, DMD (Docket Nos. starting DN-02-003) Transcript pages 1853, 1856, 2005, 2006 and 2007 (5 pages)

55. Photocopy of July 31, 2012 Subsequent Dentist Radiographs of Patient A with Dr. David Satloff's initialed and dated handwritten notations (1 page)

56. Digital Photographic Images of Slide, labeled on front as "jawbone; bone marrow fibrosis at the border of the cav." Labeled on back as "Zithromax" (2 pages)

57. US Patent #5188107; Yoshiaki Omura, February 23, 1993; Bi-Digital O-Ring Test for Imaging and Diagnosis of Internal Organs of a Patient; 15 claims, 11 drawing sheets (16 pages)

58. Digital Radiograph Image of Unidentified Patient (used in Respondent's Expert Witness Dr. Just's demonstration) (original in Prosecuting Counsel's possession)

59. Photocopy April 26, 2014 Dr. Balamas Radiographs of Patient A, 1 page

60. Digital Photographic Image of 1 Zithromax tablet in prescription container, 3 pages

61. Digital Photographic Image of Fish Oil container, 3 pages

62. Digital Photographic Image Various encased Slides, labeled as Human Papilloma Virus 16es 16, 1 page

63. Digital Photographic Image Various encased Slides, labeled as homocysteine (L), 1 page

64. Digital Photographic Image Various encased Slides, labeled as integrin, 1 page

65. Digital Photographic Image Various encased Slides, labeled as oncogene c-fos Ab2, 1 page

66. Redacted Digital Photographic Image dated February 21, 2012 by Dr. Balamas of Patient A with Dr. David Satloff's initialed and handwritten notations, 1 page

67. Photocopy of image of replica Paperclip used in demonstration by Respondent[17].

VI. NOTICE TO PARTIES

This Tentative Decision has been filed today, with Vita Berg, Chief Board Counsel. Parties may file objections to the Tentative Decision within thirty (30) days of today. Objections should be filed with Vita Berg, Chief Board Counsel, 239 Causeway Street, Suite 500, Boston, MA 02114. Any objections filed must also include written arguments in support thereof as the Board will not hold oral arguments on the objections. Parties may also file responses to objections within twenty (20) days of receipt of a copy of the objections. If a party has an inquiry regarding the Tentative Decision, that party must notify Attorney Berg by email (Vita.Palazzolo@MassMail.State.MA.US) and must "cc" the other party in that email. If the inquiring party does not have an email or does not know the email address of the other party, then the inquiry must be made to Attorney Berg by mail at the above address with copy of the mailing to the other party. You should not contact this Administrative Magistrate.

KCC

Karen Gray Carruthers
Administrative Magistrate
Department of Public Health
Office of the General Counsel
250 Washington Street, 2nd Floor
Boston, MA 02108

Tentative Decision issued and filed: February 15, 2018

[17] The sole document marked for identification but not withdrawn by the parties was Prosecution B (234 CMR 9.00).

NOTICE TO:

VIA FIRST CLASS MAIL AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED NO. 70171450000223406266
Jeremy T. Robin, Esq.
P.O. Box 146727
Boston, MA 02114

VIA INTEROFFICE DELIVERY
Beth A. Oldmixon, Esq.
Department of Public Health
239 Causeway Street, 5th Floor
Boston MA 02114

VIA INTEROFFICE DELIVERY
Alexandra B. Rubin, Esq.
Department of Public Health
239 Causeway Street, 5th Floor
Boston MA 02114

VIA INTEROFFICE DELIVERY
Vita Berg, Chief Board Counsel
Department of Public Health
239 Causeway Street, 5th Floor
Boston, MA 02114